BALLYFERMOT LDTF TREATMENT & REHABILITATION PILOT PROJCT

Record of referral

Service User Name: ______________________________ **D.O.B.**: ___________________

Referral from: ________________________

Date of referral: ________________________

Referral to: ________________________

Reason for referral: ____

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The initial appointment is for: (please tick):

3-way meeting ☐ One-to-one with service user ☐ Other (please state):____________

Confirmed date, time and venue for appointment: if appointment has been made: __________________

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Signature of referring agency staff: ____________________________________

Date of agreement: 27th June 2011.