Shannon Social Prescribing Service Referral Form

Participant's name:	
Home Address	
Contact information (Mobile and Email address):	
Participant's DOB:	
Emergency contact details/ Support person (Name, address, contact details):	

Name of GP:	
GP Address and contact information:	
Other services involved with the participant and contact information for same.	
Reason for referral- please provide details. (isolation/mental health needs/ long term health condition/ complex social needs/ frequent GP/A&E attendance?)	

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Any personal/ medical issues that might affect participation in social prescribing? (including mental health needs, access to transport, mobility or health issues)	
Has the participant recently been in crisis? (bereavement, addiction, suicidal/selfharm, mental health crisis?)	
Is the participant motivated to change?	
Any other relevant information	

Is this a self-referral? **Yes** ☐ **No**

Or

If making the referral on behalf of someone else, do you have the consent of the person named above to make this referral **Yes** ☐ **No** ☐

Signature:			
Print name:			
Work Email:		**Contact No:**	
Date:			

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Please send completed referral forms to:

Suzanne Slattery Social Prescribing Link Worker

Shannon FRC, Respond Building, Rineanna View, Shannon Co Clare V14XV97

Email: Suzanne.slattery@shannonfrc.ie

Ph: 0871959101

Web: www.shannonfrc.com

The Participant has the right, given by the Data Protection Act of 1988, 2003 and General Data Protection Regulations (GDPR), 2018, to a copy of their personal information at any time. The Participant can get this by contacting Shannon Family Resource Centre Company. We are required to keep this information for 7 years.