

Referral Form

Tick as appropriate: **Self-Referral** **OR** **Agency Referral**

Referrer Details (if self-referral leave blank)	
Name:	
Address:	
Mobile:	Phone:
Email:	

Client Details	
Name:	DOB:
Phone:	Gender:
Email:	Nationality:
Eircode:	Ethnicity:
Address:	
Language	
Does the client speak fluent English?	
Does the client need the assistance of an interpreter?	

Person with the Alcohol/Other Drug Problem	
Relationship to Client:	Age:
Substance(s) of Use:	

Reason for Referral

AFI Family Support Service

Supporting those affected by a family member's alcohol or other drug use



Is the client currently (or previously) experiencing any of the following?				
Domestic Abuse <input type="checkbox"/>	Drug Related Intimidation <input type="checkbox"/>	Mental Health Issues <input type="checkbox"/>	Homelessness <input type="checkbox"/>	Other <input type="checkbox"/>
Briefly outline:				
Support – Agencies or Organisations supporting the client/family (currently or previously)				
Any Additional Information				

Referrer Signature (if self-referral leave blank)	
<ul style="list-style-type: none"> I confirm that the client has consented to this referral 	
Signature:	Date:

Client Signature	
<ul style="list-style-type: none"> I consent to being contacted by AFI Family Support Service I agreed that this information may be shared with AFI Family Support Service 	
Signature:	Date:

Please return completed form to:
 Families Matter, Alcohol Forum Ireland, Unit B9, Enterprise Fund Business Centre, Ballyraine,
 Letterkenny, Co. Donegal, F92 CX47
 T: 074 912 5596 E: familiesmatter@alcoholforum.org W: www.alcoholforum.org