Social Prescribing Referral Form

Marion Godley

Social Prescribing Link Worker, Ballyheigue Family Resource Centre
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Details of person being referred

Name:

Address:

Date of Birth: Phone:

GP Name: GP Practice Name:

☐ Please tick to indicate that the Referred person consents to this referral and subsequent contact..

Referrer details

Name:

Organisation:

Role

Phone: Email:

What are your reasons for referral and hopes for how Social Prescribing will support this person?

Is the person linked into any other services?

Please include any additional information that may be useful, e.g. language / accessibility barriers etc.

Are you aware of any concern or risk involved in working with the Referred person or referring them to community groups? ○ Yes ○ No

Is the referred person homebound? ○ Yes ○ No

Is the referred person currently in crisis? ○ Yes ○ No

If you have ticked yes, please contact the Link Worker to discuss, before proceeding with this referral.

Referrer signature: Date:

Office use only. Date Received: Date Processed:

Health & Wellbeing Community Referral | Family Resource Centre National Forum Supporting • Strengthening • Empowering | National FRC Mental Health Promotion Project | Cúram Sláinte Pobail Corcaigh Ciarraí Cork Kerry Community Healthcare | HSE

www.thewellbeingnetwork.ie/social-prescribing