To access any MYPAS service, please complete this form

**Please note that referrals can also be made by phoning, emailing or sending a letter*

If you are a young person please fill in boxes 1 to 4. Referrers please fill in boxes 1 to 5

1. Details of Young Person

Name:

Address:

Postcode:

*Contact Telephone:
Mobile:
Email:

**if possible, a mobile number is preferred*

Date of Birth:

Is it ok to contact you by? Please tick ALL that apply

By Letter	Yes ☐	No ☐
By Phone	Yes ☐	No ☐
By Email	Yes ☐	No ☐
Is it ok to leave a message?	Yes ☐	No ☐

2. Any known Medical/Health conditions:

Prescribed medication:

3. If you can, please tell us why you are contacting MYPAS:

4. If you know what service you are interested in, please tick:

Counselling ☐ Drug/Alcohol service ☐ LGBTQ Support ☐

Art Therapy ☐ Family Counselling ☐

5. Name of referrer:

Contact Tel:

Mobile:

Name and address of agency (if appropriate)

Is the young person aware of and consents to this referral? Yes ☐ No ☐

For internal use only:

Date referral received: _____ Referral received by: _____