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: | Date of Birth: | |
| Address: | Is it ok to contact you by? Please tick ALL that apply | |
|  | By Letter Yes No | |
| Postcode:  \*Contact Telephone: | By Phone Yes No | |
| Mobile:  Email: | By Email Yes No | |
|  | Is it ok to leave a message? Yes No | |
| *\*if possible, a mobile number is preferred* |  | |
| **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 | | |
| 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: | | |