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 SupportArt 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:  |