Solace CAFÉ
Hope · Comfort · Support

The Solace Café

Introduction Form

REFERRER DETAILS:

Category of referrer:

- ☐ Local NGO
- ☐ Primary Care provider
- ☐ ARCHES
- ☐ Recovery College
- ☐ Community Mental Health Team
- ☐ Liaison Psychiatry
- ☐ Crisis Resolution Team
- ☐ Other: _____

Referred by (please print in block capitals): _____

Email: _____

Contact number: _____

Signed: _____ **Date:** _____

CLIENT/CUSTOMER DETAILS

Name (please print in block capitals): _____

DOB: _____

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Geographical location (South County Dublin): _____

Gender:

- ☐ Male
- ☐ Female
- ☐ Non-binary
- ☐ Prefers not to say

Is client living alone?

- ☐ Yes
- ☐ No
- ☐ Not sure

Can client speak English?

- ☐ Yes
- ☐ No

GP details:

Name: _____

Address: _____

Emergency Contact Details:

Name: _____

Contact number: _____

Has your client given permission to contact Emergency Contact if deemed necessary?

- ☐ Yes
- ☐ No

REASON FOR INTRODUCTION:

NEXT STEPS:

Please email this referral form to hello@solacecafe.ie. Within 24hrs, a member of The Solace Café team will be in touch with your client/customer directly via the details provided to book them a suitable appointment.