



cancer fund
for children

YOUNG SHOULDERS REFERRAL FORM



We can help...

by offering specialist therapeutic services to families where a parent (of children aged 0-24) is diagnosed with cancer.

Our support is available to families where a parent has been diagnosed within the last year.

FOR OFFICE USE ONLY

Diagnosed Parent

Name: _____

Date Received: _____ Ref. number: _____

Section 4: Referrer Information

Title	<input type="text"/>	First name(s)	<input type="text"/>	Surname	<input type="text"/>
Job Title	<input type="text"/>				
Address	<input type="text"/>				
Postcode	<input type="text"/>	Email	<input type="text"/>		
Telephone	<input type="text"/>		Mobile	<input type="text"/>	
Signature	<input type="text"/>			Date	<input type="text"/>

Section 5: Background Information

Impact of cancer on family and need for support.

Section 6: Specific Service Family May Want To Avail Of

- Individual Support for child/young person (8-24 years old)
- Group Work for child/young person (8-17 years old)
- Therapeutic Short Breaks at Daisy Lodge
- Parental Support

Section 6: Consent for Referral (Must be completed by diagnosed parent)

I confirm that I give consent for this referral to be made on my behalf to Cancer Fund for Children.

Signature Date

Once you have completed this form please return it to:

The Services Administrator
Cancer Fund for Children,
Curlew Pavilion,
Portside Business Park,
Airport Road West,
Belfast,
BT3 9ED

If you need help completing this form please contact us on:

T: 028 9080 5599

E: services@cancerfundforchildren.com



cancerfundforchildren.com

NI Charity Commission No. NIC100532

Cancer Fund for Children is registered as a data controller with the Information Commissioner's Office. Our Registration Number is Z1792224. All personal data obtained by Cancer Fund for Children is stored securely in accordance with the principles of the General Data Protection Regulation (GDPR).

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<input type="checkbox"/> New Referral	Signature of Manager	<input type="text"/>
<input type="checkbox"/> Re-referral	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="checkbox"/> Relapse	Allocated to (Specialist)	<input type="text"/>