# lssc logo.gifLSSC Counselling Referral Form

Location:\_\_\_\_\_\_\_\_\_\_\_\_

Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(To be used for referrals to Adult (25+) & Youth (14-24) Counselling Services)

## Referral Guidelines

1. To refer a potential client, please complete this form and return it to **LSSC Counselling Service, Upper Henry Street, Limerick.** Referral will be acknowledged by post/email. Prospective client will be contacted to verify referral. **Intake Assessment** will be offered within 2 to 3 weeks. Dependent on the outcome of Assessment either; Client will be offered **Ongoing Counselling**, **OR** reverted to Referrer with reasons outlining return (usually the assessment may indicate level of needs beyond our scope, or referral more appropriate to other agency).
2. Issues appropriate for Referral to LSSC Counselling Service: **Depression: reactive, Relationship Difficulties, General Anxiety and mild specific phobias, Loss, Coping with injury or illness, Life cycle developmental issues, Adjustment problems, Stress and trauma, Psychosexual difficulties, Anger, Abuse, Self Esteem etc.**

## Client Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: | |  |  | Date of Birth: |  |
| Address: | |  |  | Gender: |  |
|  |  | |  | Phone No: |  |
| Email:  **GMS Patient?** | Yes No | |  | Parent *if Client 16 or 17 yrs old* |  |

## Referral Information

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| --- |
| **Reason for referral:**   Anxiety/Stress  Depression  Relationships Work Issues  Trauma  Physical Problems  Developmental  Adjustment  Self Esteem Living/Welfare   Addictions  Psychosexual  Personality Problem Abuse Anger   Bereavement  School Issues  Bullying  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Notes on Referral:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Relevant Medical History:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **If Client is 14 to 18 years old:**  Name of Parent/Guardian(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parent/Guardian) consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_(name) my son/daughter to attend the LSSC Counselling Service. |
| Referrer Information Person making Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Office Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of GP if not Referrer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other Significant Information: |
|  |

## For Internal Lssc Use Only (Date and signature required)

Date on WL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Acknowledged receipt to referrer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Initial Ass: \_\_\_\_\_\_\_\_\_\_\_\_\_ Accepted for OG therapy? \_\_\_\_\_\_\_\_\_\_\_

No? Closure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Ongoing Therapy: \_\_\_\_\_\_\_\_\_\_

Closure: Revert to referrer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_