LIGHTHOUSE

Professional Referral Form

Lighthouse is a community based organisation that promotes and supports positive mental health and supports those affected by suicide.

To ensure that we can best meet the needs of your client we ask that you complete ALL SECTIONS of this form and send it to us. Please email to: **referrals@lighthousecharity.com** or post to: Lighthouse, Professional Referrals, 187 Duncairn Gardens, BELFAST, BT15 2GF (Tel: 90755 070)

Before you complete this form, please see section 8, Suitability for Services, ensuring that the client you wish to refer meets our referral criteria.

1. Referrer's Details

Details about the person who is making the referral

Referrer Name:		Profession:	
Organisation:		Telephone:	
Email:			
Address:			

2. Client's Details

Details about the person you wish to refer to Lighthouse

Client's Name:		Date of Birth:	
Phone (Mobile): ☐		Phone (Alternative): ☐	

Please indicate if we CANNOT leave a voicemail ☑ (Indicate)

Address: ☐	

Please indicate if we CANNOT post mail to this address ☑ (Indicate)

3. Safety Contact Details

Details of the client's next of kin, or nominated support person.

Name:		Relationship:	
Phone (Mobile): ☐		Phone (Alternative): ☐	

Please indicate if we CANNOT leave a voicemail ☑ (Indicate)

4. GP/other Professional Details

Please detail other professionals who are involved in the client's care. Beginning with the client's GP. If the professional is aware you are making this referral please indicate this. If you have referred the client to other services, please also note them below.

GP Name : .... Telephone: ....
Practice: ....
....

Professional name : .... Profession: ....
Organisation: .... Telephone: ....
Email: ....
Address: ....
....

4. Referral details

Use the space below why you are making the referral. It is important to highlight any areas of risk, specifically any history of suicide or suicidal ideation.

5. Services for which the client is being referred

Please indicate (☑) which service{s) you are referring the client for:

☐ Short Term Counselling
☐ Alternative Therapies
☐ Befriending
☐ Youth Group
☐ Bereavement Support
☐ Crisis Intervention

Please note that our counselling service is short-term (6-12 weekly sessions).

6. Consent

☑ (Indicate) If the client is under 18, has a parent or guardian been informed? (indicate (☑): Yes: ☐ No: ☐	☑ (Indicate) Has the client agreed to this referral being made? (indicate (☑): Yes: ☐ No: ☐

7. Additional details

☑ (Indicate) 1. Is the client engaged with another service? (indicate (☑): Yes*: ☐ No: ☐ *Specify:	☑ (Indicate) 2. Does the client have dependency issues or a history of? (indicate (☑): Yes*: ☐ No: ☐ *Specify:
☑ (Indicate) 3. Does the client have a disability? (indicate (☑): Yes*: ☐ No: ☐ *Specify:	☑ (Indicate) 4. Does the client have any specific language or literacy requirements? Yes*: ☐ No: ☐ *Specify:

8. Suitability for Services

To ensure that we can meet your client's needs, please review the criteria below.

Issue	Inclusion	Exclusion
Source of referral to agency	Primary and Secondary Care Mental Health Professionals GP's, Social Workers Youth Worker's, Secondary School, College/FE Voluntary/Community Groups	GP's referring clients for **counselling service**. GPs referring clients for counselling should do so via the Mental Health Wellbeing HUB.
Suicide	Client has suicidal thoughts or a history of the same. OR Client is bereaved by suicide. OR Further escalation in distress may put client at risk of suicide. OR Client has no suicidal thoughts.	Client is at immediate risk of suicide (requires 'stepped up'). In this case, the client should be referred to Tier 3 or 4 services.
Assessment Following	The referral agent has spoken with the client about Lighthouse's services and has agreed to the referral being made. AND The referral agency has conducted a face to face assessment of the client's needs, and a risk assessment. AND The referral agency states which service(s) they are referring the client to Lighthouse for.	The client has no GP AND/OR no fixed abode. The client has no support person who can be named on the referral form. The agency has made a referral to another agency for the same service.
Trust follow-up	Following assessment the client **does not** require longer term follow-up by Trust Mental Health Services. Some patients may require a brief period of crisis management within the Trust prior to the referral, but are otherwise suitable for a STEP DOWN to this service and meet the other criteria.	Requires long-term follow-up by the Trust Mental Health Services This group is not excluded from Lighthouse's services, GIVEN THAT our services complement those which are being offered by Trust Mental Health Services.
Age	Age for services 12yrs +. 12-18 services offered are: Art Therapy, Youth Group.	Clients aged under 12.

	12-16 year old's must be accompanied by adult to services.	
Alcohol/Drug misuse issues	No issues OR The client has a relationship with drugs/alcohol, however, they are not alcohol or drug dependant.	The client is alcohol or drug dependant. The client requires detoxification services at the time of assessment.
Sexual Abuse	No issues OR The client may have been victim of sexual abuse or sexual assault, which may be a factor in their distress, however this is not the core issue.	The client is seeking counselling to address issues specific to being victim to sexual abuse or sexual assault. In this case the referrer should signpost the client to NEXUS or ROWAN Centre.
Troubles Related Trauma.	No Issues OR The client may have been victim or troubles related trauma, which may be a factor in their distress, however this is not the core issue.	The client is seeking counselling to address issues specific to being victim of troubles related trauma. In this case the referrer should signpost the client to WAVE Trauma, Bridge of Hope or Everton Trauma Team.
Psychiatric diagnosis	No Issues	The client has personality disorder, psychosis or schizophrenia.
Geographic Location	The client lives within the North Belfast area.	Clients who do not reside within North Belfast are NOT excluded from the service, however the referrer should first consider the client's catchment area. AND/OR The client is unable to travel to Lighthouse's location.
Recent discharge from Counselling	If you are referring for counselling: The client has not had counselling within the last 4 months.	The client has had counselling within the last 4 months and is being referred for more of the same.

9. Communication with the referrer

Lighthouse will communicate with the client's referrer (and GP) about services offered to the client in Lighthouse, or, if we refer or signpost them to other organisations.

If we are unable to contact the client by telephone, we will write to them. If they do not respond we will let you know by letter. We will also let you (and the client's GP) know when they are discharged.

Our services are delivered on weekdays, from Monday – Friday 9:00 – 5:00. We are unable to provide services outside these hours.

10. Declaration

As the referrer, I give permission for my details to be stored by Lighthouse and consent to Lighthouse contacting me with regards to the progress of this referral (see **‘9. Communication with Referrer’** above).

Signed: Date:

Print Name: