Limerick Social Service Council CLG

Comhairle Sheirbhís Sóisialta Luimnigh CLG

Case No:

Child & Family Service Referral Form

Details of Parent/Guardian/Child Being Referred

Person being referred is an ◯ Adult ◯ Child ◯ Parent/Guardian

Name:		
DOB:		If pregnant, expected delivery date:
Address:		
Tel:		
Email:		
Name of GP:	Contact No.	
Primary Language:		Does the person need an interpeter? ◯ Yes ◯ No

*__Please note:__ If parents/guardians are separated, provide a separate referral form for each parent/guardian being referred to the service.

Please indicate to which service you would like to refer the Parent/Guardian/Child:

◯ Community Social Work and Family Support Service: Targeted one to one and group support for parents and children from birth to age 18

◯ The Community Mothers Programme: One to One and Group support for parents from the ante-natal period to the age of three

◯ The Teen Parents Support Programme: Targeted one to one and group support for young people who are pregnant or young parents

◯ Parenting Teenagers: The Relationships and Sexual Health Programme: One to one and group support for parents of teenagers and teenagers in the areas of relationships, commnication and sexual health

◯ The Family Advocacy Service: Support for parents who have children in the care of the State

◯ Groups - Please specify _____ ◯ 0-1 ◯ 1-6 ◯ 6-12 ◯ 12-18

Please send all referrals, marked private and confidential, to

LSSC Child and Family Support Manager, Upper Henry Street, Limerick. E: cfsreferral@lssc.ie T: 061-314111

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If the referral is for a child, please complete information for all parent/guardian present in the child's life:

First name:	Surname:	Relationship to the child or young person:

Other family and household members (including brothers and sisters, step-parents and any other person living in the household)

First name:	Surname:	Relationship to the child or young person:	Age/DOB

Professionals who work with the child/ren or family, e.g. GP, PHN, school, childcare service etc:

Name and title:	Organisation:	Telephone/email:	Working with:

Is the family currently engaged with TUSLA? ◯ Yes ◯ No ◉ Unknown

Any special requirements? E.g. (Visual or hearing equipment; wheelchair access; sensory issues etc.)

What support is your organisation currently providing to the family?

What are you concerned about? What support would you like to see offered by LSSC?
Include prompts such as physical and mental health, emotional and social development, relationships, living environment, child protection/welfare, etc.

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What is working well for the child and family? What are the strengths of the family?

What would you like to see change for the family as a result of this referral?

Please let us know if there is anything else that we should be aware of that may have an impact on the safety or welfare of the family or may be relevant to the referral (such as legal orders, assessments, reports, diagnosis of intellectual ability etc.).

Consent:

Do you confirm that the person referred (or their parent/legal guardian if under 18) has consented to this referral and understands the purpose of the referral? ◉ Yes ◯ No If yes, who?

Do you confirm that the person referred understands that their personal data will be shared with LSSC and will be stored by us in accordance with our obligations under GDPR? ◉ Yes ◯ No If yes, who?

Referrer's Details:

Name:	Job Title:	Service/Agency:
Address:		Tel: Mobile: Email:

I confirm that the information above is complete and accurate to the best of my knowledge.

Signature of Referrer: Date:

Internal Use Only:

Received by:	Date:	Signed:
Assigned to:	Date:	Department: