LEARNING THROUGH LOSS
hope | healing | community

Grief Counselling Referral Form

Friends of Living and Learning Through Loss is providing virtual short-term grief counselling support for youth aged 13-24 experiencing grief, loss and bereavement. Reasons for referral include the death of a parent, sibling, family member, or friend. These services are provided at no cost to youth.

Please note LTL does not provide complex trauma counselling services.

Requirements and responsibilities for acceptance into grief counselling:

- Youth who reside within the CRD
- Voluntary participation and commitment to attending all of the sessions
- Participants are not under the influence of alcohol and/or other drugs
- A completed referral form below

To make a referral, please complete in full and email the form below to: **info@learningthroughloss.org**

Referral Date:		**Referred by:**	
Agency or Relationship:		**Phone:**	
Client Last Name		**First Name**	
Birth Date/Current age:		**M/F/Pronoun**	
School, District & Grade		**Phone:** **Cell/Home**	
Email:			
Full Address:			
Permission to text? **Permission to leave voicemail?** **Permission to use email?**	Yes No Yes No Yes No		
Emergency Contact Info.			
Name:			
Phone:			
Relationship to Client			

Additional Information	
Name of person who died	
Relationship to client	
Cause of Death	

132-328 Wale Road · Victoria, BC V9B 0J8
Telephone: 250.413.3114
Email: info@learningthroughloss.org · Website: www.learningthroughloss.org

Date of Death	
Age of client at time of death	
Was client present at time of death?	

Describe what brings this youth in for counselling.

What are the primary concerns for the client and what are the goals for short-term counselling?

Additional comments:

Please list all professionals (psychologists, psychiatrists, counsellors, social workers, etc) and facilities (schools, hospitals, community organizations) that have provided psychological evaluation and/or treatment for this youth.

Type of Services (counselling, school, etc)	**Provider**	**Dates of Service**

Use of current medications this youth is taking and the condition which is being treated.

Medication	**Condition Treated**

Check any symptoms this youth is currently exhibiting:

Sadness		Self Harm		Irritability		Headaches	
Change in Appetite		Suicidal thoughts		Nighmares		Stomach aches	
Change in sleep		Difficulty concentrating		Relationship difficulties		Avoidance	
Hopelessness		Lack of interest in activities		Lack of energy/fatigue		Separation anxiety	
Anger		Mood Swings		Fear		Hyperactivity	