**BEREAVEMENT SUPPORT TEAM: COUNSELLING SERVICES ADULT CLIENT REFERRAL FORM (Website)**

**For office use only**

|  |  |
| --- | --- |
| **Date of Receipt:** | **Client Ref Number:** |
| **Client NHS Number:** | |
| **Client’s potential availability:** | |

**Section 1 to be completed by the referring agency or GP**

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| --- |
| **Referrer’s Name:**  **Referrer’s Role/Organisation:**  **Referrer’s Address:**  **Referrer’s Contact Number:**  **Referrer’s Email address:**  **Has the adult you are referring given consent for the referral to be made?** Yes / No  **Has the adult you are referring given their permission for contact to be made to relevant agencies and organisations to exchange information if required and deemed necessary?**  Yes/ No |

**Section 2 to be completed by the referring agency, GP or self-referring adult**

|  |  |  |  |
| --- | --- | --- | --- |
| **Adult’s Name:** | | | |
| **Adult’s Address:** | | | |
| **Post Code:** | | | |
| **Adult’s** **Landline Telephone Number:**  **Can a message be left?** Yes / No | | | |
| **Adult’s Mobile Number:**  **Can a message be left?** Yes / No | | | |
| **Adult’s Email address:** | | | |
| **Adult’s Date of Birth:** | | | |
| **Adult’s NHS number:** | | | |
| **Adult’s Ethnicity:** | | **Adult’s Religion:** | |
| **Adult’s General Practitioner/Practice Name and Address:** | | | |
| **Reason for Referral:** Please complete number 1 **or** number 2   1. **Anticipatory Grief (Pre-Death)**     **Who has been diagnosed?**  **When was the diagnosis?**  **What is the nature of the illness?**   1. **Bereavement (Post death which has to be a minimum of 6 weeks after the death)**   **Who has died?**  **What was the cause of death?**  **What was the date of the death?**  **What signs or symptoms are being experiencing?**  **Why is Counselling Needed?** | | | |
| **Are there any identified risks for the adult?**   |  |  | | --- | --- | | Self-Harm  Suicidal thoughts  Suicidal attempts  Mental Health  Drug/Alcohol Abuse  Domestic Violence | YES / NO  YES / NO  YES / NO  YES / NO  YES / NO  YES / NO | | | | |
| **Is there a history of Physical Aggression/Verbal Aggression/Challenging Behaviour:** Yes / No  **Please state:** | | | |
| **If answer is YES please mark as necessary:** | Friend  Family  Carer  School  Anyone  Any other  Professional | | YES / NO  YES / NO  YES / NO  YES / NO  YES / NO  YES / NO |
| **Any other agencies involved?** Yes / No  **If yes who?** | | | |
| **Any known disability or communication needs?** Yes / No  **If yes please give details:** | | | |
| **Any known health issues e.g. Epilepsy/ADHD:** Yes / No  **If yes please give details:** | | | |
| **Any diagnosed/undiagnosed mental health conditions?** Yes / No  **If yes please give details:** | | | |
| **Any additional information which you feel may be useful?** | | | |

Completed forms can be returned securely via email to [NECNE.StCuthbertsHospiceReferrals@nhs.net](mailto:NECNE.StCuthbertsHospiceReferrals@nhs.net)