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

**For office use only**

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| **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**

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| **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?**

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| Self-HarmSuicidal thoughtsSuicidal attemptsMental Health Drug/Alcohol AbuseDomestic Violence  | YES / NOYES / NOYES / NOYES / NOYES / NOYES / NO |

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| **Is there a history of Physical Aggression/Verbal Aggression/Challenging Behaviour:** Yes / No**Please state:** |
| **If answer is YES please mark as necessary:** | FriendFamilyCarerSchoolAnyoneAny other Professional | YES / NOYES / NOYES / NOYES / NOYES / NOYES / 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