# CONFIDENTIAL BEREAVEMENT SUPPORT TEAM: COUNSELLING SERVICES CHILD/YOUNG PERSON 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, GP or parent/guardian**

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| **Referrer’s Name:****Referrer’s Role/Organisation:****Referrer’s Address:****Referrer’s Contact Number:****Referrer’s Email address:****Has the child and parent guardian you are referring given consent for the referral to be made?** Yes / No**Has the child and parent guardian 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 parent/guardian**

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| **Child’s Name:**  |
| **Parent/Guardian Name:**  |
| **Child’s Address:** |
| **Postcode:** |
| **Parent/Guardian Landline Telephone Number:****Can a message be left?** Yes / No |
| **Parent/Guardian Mobile Number:****Can a message be left?** Yes / No |
| **Parent/Guardian Email address:** |
| **Child’s Date of Birth:** |
| **Child’s NHS number:** |
| **Child’s Ethnicity:** | **Child’s Religion:** |
| **Child’s General Practitioner/Practice Name and Address:** |
| **Child’s School 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 months 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 experienced?****Why is Counselling Needed?** |
| **Are there any identified risks for the child?**

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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**If yes 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