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**Broad Lane, Rochdale, OL16 4PZ**

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**COUNSELLING SERVICE REFERRAL FORM**

**□ Patient living with a life-limiting condition or □ Relative/Carer of a patient living with a life-limiting condition**

\*\* Please note there is a separate referral form for the bereavement service

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| **Has the client consented to this referral? Yes □ No □**  **Please note this referral will only be processed if the client is aware and has given consent** |

**Client details:**

|  |  |
| --- | --- |
| Surname: | Date of Birth: |
| First name: | Title: |
| Address: | Gender: |
| Ethnicity: |
| Religion: |
| Postcode: | Language: |
| Landline No:  **Consent to leave a message** **Yes □ No □** |  |
| Mobile No:  **Consent to leave a message** **Yes □ No □** | Does the client have a disability? Yes □ No □  Please describe: |

**Further information if the Client is a Patient:**

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| --- | --- |
| Diagnosis: | Date of Diagnosis: |
| Hospital Number: | Is the patient housebound? Yes □ No □ |
| NHS Number: | Does the patient live alone? Yes □ No □ |

**Next of Kin/Carer details:**

|  |  |
| --- | --- |
| Surname | Address: |
| First name: |
| Relationship to patient: | Postcode: |
| Tel: |

**Referrer details: \*Must be a qualified health professional**

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| Name: | | | Address: | | Tel: |
| GP □ | Consultant □ | Specialist Nurse □ | | District Nurse □ | Other □ (specify) |

**GP/Other services involved:**

|  |  |
| --- | --- |
| GP name:  Address:  Tel: | Specialist Nurse name:  Tel: |
| District Nurse name:  Tel: |
| Other (please specify) |
| **Client Name:**  **Reason for referral:**  Anxiety 🞏 **Comments:**  Depression 🞏  HAD Score\_\_\_\_\_\_\_\_\_/ PHQ-9\_\_\_\_\_ GAD-7\_\_\_\_\_\_\_  Difficulty adjusting to diagnosis/treatment 🞏  Body image problems 🞏  Issues around caring 🞏  Lack of self-confidence 🞏    **What does the client hope to get out of counselling?** | |

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| **Is the client under the care of a psychiatrist: currently Yes □ No □ or previously Yes □ No □**  Name:  Address:  Tel:  **Are mental health services involved? Yes □ No □**  (please give as much detail as possible along with contact details)  **Other psychological history? Previous counselling? Yes □ No □**  (please give as much detail as possible) |

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| **Risk of self-harm? Yes □ No □**  (please give as much detail as possible)  **Risk to others? Yes □ No □** |

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| **Is client prescribed medication for anxiety and/or depression?**  Please list medication, start date and dose: |

**Please complete ALL sections to avoid delays in processing this referral**

|  |  |
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| **Person completing referral:**  Print Name:  Signature: | Designation:  Tel:  Date: |