SPRINGHILL HOSPICE
Broad Lane, Rochdale, OL16 4PZ
Tel: 01706 649920 Fax: 01706 644943 Email: hmrccg.liaison@nhs.net

REFERRAL FORM

****Please complete in full****

Request for:

COUNSELLING SERVICE □

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

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:	Sex:
Address:	Ethnicity:
	Language:
Postcode:	Marital status:
Tel: **Consent to leave a message Yes □ No □**	Mobile No: **Consent to leave a message Yes □ No □**

Further information if the Client is a Patient:

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:	
	Postcode:
Relationship to patient:	Tel:

Referrer details: *Must be a qualified health professional

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

GP/Other services involved:

GP name: Address: Tel: Fax:	Specialist Nurse name: Tel:
	District Nurse name: Tel:
	Other (please specify)

Client Name: **Reason for referral:**	
Anxiety ☐ Depression ☐ HAD Score_____/ PHQ-9_____ GAD-7_____ Difficulty adjusting to diagnosis/treatment ☐ Body image problems ☐ Issues around caring ☐ Lack of self-confidence ☐	**Comments:**
What does the client hope to get out of counselling?	

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)

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

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

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