****

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

**Tel: 01706 649920 Email:** nehgm.liaison@nhs.net

**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

|  |
| --- |
| **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:**

|  |  |
| --- | --- |
| 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**

|  |  |  |
| --- | --- | --- |
| 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?** |

|  |
| --- |
| **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: |