SPRINGHILL HOSPICE
Broad Lane, Rochdale, OL16 4PZ
Tel: 01706 649920 Fax: 01706 644943

REFERRAL FORM

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

Request for:

COUNSELLING SERVICE ☐	**BEREAVEMENT SERVICE** ☐ MUST BE 3 MONTHS POST BEREAVEMENT

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

Patient/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 ☐**

Patient information:

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:

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)

Patient Name:
Reason for referral:

Anxiety ☐	Bereavement ☐
Depression ☐	Date of loss (Must be 3 months post bereavement)
HAD Score_____/ PHQ-9_____ GAD-7_____	Relationship ……
Difficulty adjusting to diagnosis/treatment ☐	Circumstance (please give as much detail as possible)
Body image problems ☐	
Issues around caring ☐	
Identity issues ☐	
Lack of self-confidence ☐	
Relaxation techniques ☐	
Comments:	

What does the client hope to get out of counselling?

Is the patient/client under 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? 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 patient/client prescribed medication for anxiety and/or depression?
Please list medication, start date and dose:

Please complete all sections to avoid delays in processing the referral

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