Thames hospice

COUNSELLING & BEREAVEMENT SUPPORT - MAIN REFERRAL FORM

Please complete this form using capital letters

Please send your completed referral form by email to TH.PFSTeam@nhs.net

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TYPE OF REFERRAL (please tick one box):

- **Counselling** for a palliative patient or their partner/carer/relative ☐

OR

- **Bereavement support** for a partner/carer/relative of a palliative patient who has died ☐

CONSENT AND COMMUNICATION (please ensure this is complete before referring):

Is the person you are referring aware the referral is being made? **YES / NO**

Is the person's GP aware this referral is being made? **YES / NO**

PATIENT DETAILS (please complete all of this section):

Surname: First name(s):

Date of birth:

Address:

Postcode: Telephone number (s):

Gender: Marital status: Ethnicity:

Diagnosis:

NHS Number: Email address:

Does the patient live alone? **YES / NO** Date of death (if applicable):

PALLIATIVE VERIFICATION:

Please confirm that the patient is/was receiving specialist palliative care services: **YES / NO**

Name of Palliative Care Consultant or Palliative CNS in the community or hospital:

Name of Hospice (if applicable):

CLIENT DETAILS (only complete this section if the person you are referring is not the patient):

Surname: First name(s):

Date of birth:

Address:

Postcode: Telephone number (s):

Gender: Marital status: Ethnicity:

NHS Number: Email address:

Does the client live alone? **YES / NO** How is the client related to the patient?

FAMILY DETAILS (describe family situation or depict family tree)

GP DETAILS:

GP name:

GP address:

GP telephone number: GP e-mail:

OTHER SERVICES OR AGENCIES INVOLVED:

District Nurse - name: Telephone number (s):

Social Worker - name: Telephone number (s):

Other agency - name: Telephone number (s):

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REASONS FOR REFERRAL (MARK WITH 'X' ALL WHICH APPLY):

Anxiety	☐	Not coping with treatment	☐	Loss of loved one	☐
Low mood	☐	Body image problems	☐	*Date of loss:*	
Depression	☐	Issues around care	☐	Complicated bereavement reaction *Explain circumstance:*	☐
Frustration	☐	Not coping with diagnosis	☐		
Anger	☐	Not coping with prognosis	☐		
Loss of independence	☐	Unrealistic thinking	☐		
Loss of confidence	☐	Family/relationship issues related to diagnosis	☐	Family/relationship issues related to bereavement	☐
Identity issues	☐	Isolation/Loneliness	☐		

Other relevant details:

MENTAL HEALTH OF THE PERSON YOU ARE REFERRING:

Previous and present psychological/psychiatric history:

Risk of self-harm: **YES / NO** Suicidal ideation: **YES / NO**

On prescribed medication for depression and/or anxiety: **YES / NO**

REFERRER DETAILS:

Your name:
Your address:
Your telephone number: Your e-mail:
Your profession: Your signature: Date of referral:
