REFERRAL FORM

COUNSELLING & BEREAVEMENT SUPPORT

Email to: admin.eastlancashirehospice@nhs.net
Tel Numbers for Clinical Administration: 01254 916983/965864

ACCEPTANCE CRITERIA

- The individual is aged 18+
- The individual and/or a loved one has been diagnosed with a life-limiting/palliative condition.
- The individual has suffered a bereavement within the past 3 years.
- The individual must be registered with a GP in Blackburn, Darwen, Hyndburn or the Ribble Valley.

Note: We are not able to meet the needs of people with complex mental health or substance misuse difficulties.

Data protection and confidentiality

In order to access this service, some of the information you submit will be shared with your/the individual's registered GP and may also be shared with other relevant services. East Lancashire Hospice is committed to protecting your information and privacy. We only collect your personal data for education in line with GDPR. For further information on how we collect, use and store your data please see our privacy notice available here

*** PLEASE NOTE THAT ALL FIELDS ARE MANDATORY ***

PERSONAL DETAILS

Title:	**Surname:**	**First Name:**	**Preferred Name:**	**Date of Birth:**

Address & Postcode:	**Telephone:** *(Home/Mobile)*
	Email: *(state if unknown)*
Registered GP: *(Name & address of practice)*	**NHS No:** *(if known):*
	First Language:
	Interpreter Required: Yes ☐ No ☐

Disability:

Physical Disability ☐ Learning Disability ☐ Visual Impairment ☐ Hearing Impairment ☐ Speech & Language ☐
Autism Spectrum Condition (ASC) ☐ Other or N/A (please state)

Accessibility Requirements: *(state if not applicable)*

Relevant Medical History: *(state if not applicable)*

REFERRAL DETAILS	
Nature of referral:	Counselling ☐ Bereavement Support ☐ *(Please specify)*
What involvement have you/the individual had with East Lancashire Hospice? *(state if not applicable)*	
Current issues/difficulties:	
What are you/the individual hoping to gain from this referral:	
Are any other professionals involved in your/the individual's care or support? *e.g. professional carers, family members or other organisations?*	
Yes ☐ No ☐ *If yes, please provide detail:*	
Are you/the individual currently receiving formal counselling with another service?	
Yes ☐ No ☐ *If yes, please provide detail:*	
RISK & SAFEGUARDING	
Please tick if you suffer from any of the following: Mental health condition e.g. depression or anxiety disorder ☐ Difficulties with drug or alcohol use ☐ Self-harm or thoughts of suicide ☐ Risk from others, such as domestic violence or financial abuse ☐ ***Further details:***	
REFERRER DETAILS	
*** IF SELF-REFERRING PLEASE CONFIRM YOUR CONSENT AND THEN SIGN AND DATE THE FORM ***	
Do you/does the individual consent to this referral? Yes ☐ No ☐	
Referrer Name & Role:	
Referrer Organisation:	
Referrer Contact Number:	
Signature:	**Date:**