Pendleside Hospice Care for Burnley & Pendle

Counselling Referral Form - Tel: 01282 440102 Fax: 01282 440123

CLIENT DETAILS

Surname	
First Names	
Marital Status	
Date of Birth	
Age	
If under 16 parental consent sought	
Address	
Post code	
Tel No:	
Mobile	

HEALTH OF CLIENT

Name of GP Surgery					
Physical Health					
Good		Poor		Existing Illness/Disability	
Emotional / Psychological Health					
Good		Poor		Clinically Diagnosed Mental Health Problem	

Any issues with drugs or alcohol?

Notes:

Client Availability:

If for bereavement counselling was the death?

Expected		Sudden	

Name of deceased	
Date of death	

Any other comments:

Any other bereavements:

Within the last year		Within last 2 years	
More than 2 years		Not known	

Please give details:

If pre-bereavement:

Name of patient:

What is the diagnosis?

Relationship to client:

Comments

Referrer Details

Name	
Position	

Contact details:

Client consent sought:	Yes		No	

Office use only:

Referrer informed of action taken:

Date