Dove Community Counselling Service

Referral Form (Fax:01277 632723/01277 623915)

***Please note that we require the client to be in agreement to this referral**

(Please carefully read criteria for referrals on the reverse)

Client Details:

Title: Mr / Mrs / Ms / Miss .....

First Name/s: ..... Family Name: .....

Address: ..... *Tel: Home: .....

..... Mobile: .....

..... Work: .....

Postcode: ..... *D.O.B: .....

*Privacy – Can leave message: Yes / No *Patient / Carer / Relative / Bereaved/Survivor

*Detailed reason for referral. (**Please include nature and date of loss.**) Please attach any other assessments or reports relevant to support this referral.

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*Cancer Related Referral: Yes / No *Hospice Related: Yes / No

*Ethnicity .....

G.P. Name: .....**Please indicate if any other Health Professionals**

.....**are involved now or in the past:**

E.mail..... ☐ Key Worker ☐ Social Worker

Address/Telephone:..... ☐ Advocacy ☐ TH Mind Service

☐ Other ☐ CMHT ie; Grays Hall

Referral Source: ..... Date: .....

Name of individual making referral: .....

Address: .....

.....

..... Postcode:.....

Tel: Work..... Mobile.....

For Hospice use only: *please tick relevant box(es) & briefly describe intervention required*		
	Tick	Comments
Emotional Support		
Pre bereavement support		
Post bereavement support		

Please send these details to:

Service Co-ordinator, Dove Community Counselling Service,
Dove Cottage, 4 Noak Hill Road, Billericay, Essex CM12 9UG
Tel: 01277 655039 – **Fax 01277 632723** - Email: macmillandove@stlukeshouse.org.uk
Tel: 01277 658057 – **Fax 01277 623915**

Referral Form

The main administration base for our team is at Dove Cottage, though support is provided on all sites; St Luke's House. St Luke's Hospice & The Beehive Centre.

You may refer directly to us, using the form overleaf, **please be kind enough to read the referral criteria below and provide us with the details we require.**

Referral Criteria

- clients must be **resident** within the Basildon & Thurrock district
- clients may be **patients, carers, relatives and bereaved or survivor**
- the **primary** presenting issue should be identified as bereavement within the **last five years**
- referrals should be made with the **permission** of the client.
- the service provides short term interventions for people living with or affected by cancer or any life limiting illness, bereaved people and survivors of cancer.

Exclusion

The Service is unable to accept referrals for clients who are in **acute mental health phase** or who are unable to engage in the counselling process..

(We work within the BACP ethical framework for good practice and NICE guidance)

Notes on completion

The details required are mostly straight forward; however, as we assume you will discuss the referral with the client, please ensure in particular the following information is clarified.

1. Wherever possible, our initial contact is by telephone. Please provide us with a ***telephone contact number** for this purpose.
2. The ***date of birth** is essential information. **Please do not leave blank.**
3. The ***nature and date of bereavement** helps us to prepare for initial contact with the client.
4. Bereavement cases: please indicate if ***hospice related** (St Luke's only) i.e. the death was at the hospice, or the deceased was supported by Day Hospice or Hospice at Home **please indicate this on the referral**. The hospice has a follow up process for bereavement support and we will be able to activate this on behalf of the client. For some clients this point will clearly not apply.
5. Pre-bereavement cases: please indicate if the client is a ***patient, carer or relative.**
6. Ethnicity – please provide us with the clients ***ethnicity**

***Please inform the client that you are making this referral and that initially we will contact them by telephone.**

Thank you.

Revised: April 2015