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| **COUNSELLING REFERRAL** |

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| Please complete **all shaded sections** and return to:**WELLBEING COUNSELLING SERVICE**, MACMILLAN WELLBEING CENTRE, MOORSIDE ROAD, DAVYHULME, M41 5SN**allison.courtney@mft.nhs.uk****wendy.congleton@mft.nhs.uk** **TELEPHONE: 0161 746 2080** |

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| Referral criteria: | 18 years or over Trafford resident or registered with Trafford GP |

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| Date |  | Please indicate √ : |
| CLIENT DETAILS | Bereavement |  | or | Cancer care |  |
| Face to face |  | or | Telephone |  |
| Title |  | FOR OFFICE USE ONLY:Client ID code:Family/ carers known to service? |
| Name |  |
| Address |  | D. o. B. |  |
| Gender |  |
| Ethnicity |  |
| Postcode |  | NHS number |  |
| Contacts | Home no. |  | GP name GP address GP no. |  |
| Mobile no. |  |
| E-mail |  |
| Interpreter needed? | yes | or | no | Home language |  |

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| REFERRER’S DETAILS |
| Nature of referral- please indicate √ : |
| Self |  | GP/ health professional |  |
| Family/ carer (with permission) |  | Other  |  |
| Name |  | Name |  |
| Relationship to client: |  | Address |  |
| Telephone |  |

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| Brief outline of reason for referral |  |
| Any previous counselling? |  |
| Medications |  |

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| *Received by:* | *Telephone* | *Face to face* | *Post* | *E-mail* | *Date:* |