COUNSELLING REFERRAL

Please complete **all shaded sections** and return to:
WELLBEING COUNSELLING SERVICE,
MACMILLAN WELLBEING CENTRE, MOORSIDE ROAD, DAVYHULME, M41 5SN
mft.macmillancentretrafford@nhs.net
TELEPHONE: 0161 746 2080

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

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 Phone				
	Mobile no.					
	E-mail					
Emergency Contact Name:		Emergency Contact Phone:				
Interpreter needed	YES OR NO	Home language				

REFERRER DETAILS
Please Indicate ✓

Self		GP/ health professional	
Family/ carer (with permission)		Other	
Name		Name	
Relationship to client:		Address	
		Telephone	

Brief outline of reason for referral	
Any previous counselling?	
Medications	

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