A logo with text and arrows

Description automatically generatedA white background with orange text

Description automatically generatedA logo for a university

Description automatically generated

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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  [mft.macmillancentretrafford@nhs.net](mailto:mft.macmillancentretrafford@nhs.net)  **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 |  | |

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

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