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| **SUPPORTIVE CARE 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**  **Telephone: 0161 746 2080** |

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| **Referral criteria:** | 1. 18 years or over
2. Trafford resident or registered with Trafford GP
 | **Allergy sticker:** |  |

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| Date  |   | **Please indicate** **√**:  |
| **CLIENT DETAILS** | Patient with diagnosis  |  | OR | Family/carer  |   |
| Title  |   | **FOR OFFICE USE ONLY:** Client ID code: Family/carers known to service?  | SCA date:   |
| Name  |   |
| Address  |      | D. o. B.  |   |
| Gender  |   |
| Ethnicity  |   |
| Postcode  |   | NHS number  |   |
| Contacts  Voicemail? Y / N  | Home no.  |   | GP name GP address GP no.  |   |
| Mobile no.  |   |
| E-mail  |   |
| Emergency contact  | Name  |   | Consultant  |   |
| Address  |   | Hospital  |   |
| Phone  |   | District/ Macmillan nurse  |   |

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| **REFERRER’S DETAILS** |
| Nature of referral- **please indicate** **√** : |
|  Self  |   | GP/ health professional  |   |
| Family/ carer (with permission)  |   | Other  |   |
| Name  |   | Name and role  |     |
| Relationship to client:  |   |
| Telephone  |   |
| Address  |   |
| In centre referral taken by….  |   |

 Continued over……………….

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| Diagnosis  |   |
| Reason for referral  |   |
| Current situation  |   |

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| **ADJUSTMENTS REQUIRED** |
| Accessibility (e.g. wheelchair) details  |   |
| Interpreter needed?  | **Yes / No**  | Home language  |   |
| Any other relevant information  |   |

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| **FOR OFFICE USE ONLY** |
| Client understands and accepts referral  | **Yes / No**  | Consent given for assessment  | **Yes / No**  | Consent for EMIS shared record access  | **Yes / No**  |
| Confidentiality explained  | **Yes / No**  | Compliments/ complaints procedure explained  | **Yes / No**  | Possible transport needs  | **Yes / No**  |

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