

**REFERRAL FORM FOR TIME LIMITED COUNSELLING WITH COUNSELLORS SOUTHWEST**

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| --- | --- |
| Referral date |  |
| Patient’s NHS number |  |
| Patient’s name |  |
| Patient’s address |  |
| Patient’s date of birth and age |  |
| Patient’s contact numbers and email |  |
| Can we leave a message on an answer phone |  |
| Patient’s GP |  |
| Patient’s surgery |  |
| Name of person referring  and contact number |  |
| **Name of the agency referring** if not the GP and what intervention (if any) has the patient already received? |  |
| **Equalities Monitoring Form** completed and enclosed? | Yes  No |
| Reason for referral | |
| Are this person’s difficulties:- (please select)  Low to moderate depression  emotional distress  loss  trauma  interpersonal | |
| What is the patient’s support system: family  friends  No support  limited support  good support | |
| Any areas of risk we should be aware of |  |
| Physical health |  |
| Other professionals involved |  |
| Employment status |  |
| Any other information |  |

Please return by: **POST:** Counsellors Southwest CIC, Pearl Assurance House, Brook Street, Tavistock PL19 0BN

**COURIER:** Counsellors Southwest C/O Tavyside Health Centre, Abbey Rise, Tavistock PL19 9FD

**Email:** [tricia.stewart@nhs.net](mailto:tricia.stewart@nhs.net)

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| **OFFICE USE ONLY** | **Date ref rec by CSW** |  | **Date opt in sent out** |  |