

**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 referringand 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

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