# Saint Catherine's

Caring for you at Hospice and Home

## PALLIATIVE CARE COUNSELLING / BEREAVEMENT SUPPORT REFERRAL FORM

FOR OFFICE USE

| Assessor: | Counsellor/Supporter: |
|---|---|
| Case number: | Date referred to C/S: |
| DATE OF REFERRAL: | WRITTEN/~~PHONE~~ |

**PLEASE NOTE WE ARE ONLY ABLE TO ACCEPT REFERRALS FOR:**

- **PATIENTS ALREADY REGISTERED WITH A SERVICE PROVIDED BY SAINT CATHERINE'S**
- **RELATIVES/CARERS OF PATIENTS WHO ARE OR WERE REGISTERED WITH SAINT CATHERINE'S.**

**REFERRER TO COMPLETE**

| | | | |
|---|---|---|---|
| **NAME OF THE PERSON YOU ARE REFERRING:** | | **DATE OF BIRTH:**<br>**ETHNICITY:** | |
| **ADDRESS:** | | **REFERRER'S NAME:**<br>**ORGANISATION:**<br>**CONTACT DETAILS:** | |
| **TEL. NUMBER:** 1)<br>2) | Msg. OK? | **NHS NUMBER:** | |
| **GP/SURGERY:** | | | |
| **REFERRAL FOR:** (tick one box) | ☐ **Palliative Care Counselling: Patient** – please state diagnosis: ____________ **continue on page 2.**<br>☐ **Palliative Care Counselling: Relative/Carer** - please complete section **A** below.<br>☐ **Bereavement Support** - please complete section **B** below. | | |

| **A** PATIENT'S NAME: | **B** Details of the person who died<br>**NAME:** |
|---|---|
| **RELATIONSHIP TO THE PERSON YOU ARE REFERRING:** | **RELATIONSHIP TO THE PERSON YOU ARE REFERRING:** |
| **DIAGNOSIS:** | **DATE OF DEATH (Month/Year):** |
| **ADDRESS (IF DIFFERENT FROM ABOVE):** | **CAUSE OF DEATH:** |

**PLEASE CONTINUE ON PAGE 2**

FOR OFFICE USE

| | | |
|---|---|---|
| Date contacted client | Early Days Appt. | |
| Date of assessment | | |
| DNA - Action | | |
| First session | Start letter sent | |
| Last session | End letter sent | |
| Number of sessions | Evaluation sent | HP? Date adj. |

## REFERRER TO COMPLETE

| **REASON FOR REFERRAL:** |
|---|
| **IS A HOME VISIT REQUIRED?** ☐ Yes → **REASON:**<br>☐ No<br>**FOR INTERNAL REFERRALS, PLEASE ATTACH A LONE WORKER RISK ASSESSMENT IF ONE HAS BEEN CARRIED OUT.** |
| **DETAILS OF ANY OTHER SERVICES INVOLVED**: |
| **PAST MENTAL HEALTH HISTORY**: |
| **ANY MEDICATION**: |
| **ANY KNOWN RISKS - to self, others or from home environment**: |
| **ANY OTHER RELEVANT DETAILS**: |
| **REFERRER'S SIGNATURE:** **DATE:** |

*Please return the completed form* ***BY POST*** *to:*


**Counselling & Bereavement Support Service**
Saint Catherine's Hospice
Throxenby Lane
Scarborough
YO12 5RE