**Parent Bereavement Counselling Referral Form**

We accept referrals for parents of children with life-threatened, life-limited diagnosis and bereavement.

We offer bereavement counselling to parents whose child has died whilst being supported by Evelina Children’s Hospital.

**Please complete the form below and return to:** **ParentCounsellingService@gstt.nhs.uk**

We are available Tuesday to Friday between 9am to 5pm.

If you have any questions please call: 020 7188 4538 and leave a message.

Bereavement counselling for parents / carers is provided face-to-face, or on remote video using TEAMS or by telephone between Tuesday and Friday. Our last session is 3:30 to 4:20pm.

When we receive your completed referral form, we will contact you to talk about what you feel your needs are. We offer up to 12 counselling sessions for bereaved parents / carers. You can talk to your counsellor about how you want to use the sessions. We will review our counselling at session 10 and another block of up to 8 sessions may be offered if required. You and your counselling will talk about this.

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| --- | --- |
| **Date completed:**  | **Office Use Only: Client ID** |
| **Child’s name:** **Child’s NHS or Hospital number (if available):** | **Date of Death:** |
| **Parent[s] / Carer[s] / Guardian:** If more than one person – counselling together or separately? |
| Name: Phone number: Email:  | Name:Phone number:Email:  |
| **Are there any access needs? Such as an interpreter, wheelchair access, information in large font, Yes / No****If yes, please tell us what is needed.** |
| **Counselling is available from 9:30am until 4:20pm on Tuesday, Wednesday, Thursday and Friday.****What times & days are best for you?** |
|
|  | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| **Morning**  |  |  |  |  |
| **Afternoon**  |  |  |  |  |
| Tell us if there is a specific day and time that you need: |
| **Would you prefer (tick all that apply)** | **Face-to-Face** | **Online Video** | **Telephone** |
| **Referrer details**Name and job role/title:Phone number: Email: |
| Consent has been given by me [parent] or confirmed by professional for this referral and for contact to be made by Parent Counselling Service - **Yes / No** |