**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**](mailto: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.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | | | | | | | | | |