**Parent Counselling Referral Form**

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

**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.

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| **Date completed:**  | **Office Use Only: Client ID** |
| **Child’s name:** **Main Evelina Team connected to the child:****Child’s NHS or Hospital number (if available):** | **Date of Birth:** |
| **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.** |
| **Brief** **details of current situation and its impact on parent[s]. Please use jargon free language to avoid misunderstandings.** |
| **How might counselling support you?** |
| **Name + telephone number of other professionals currently connected to child / family. This includes clinical nurse specialist, keyworker, psychologist, social worker and housing contacts.** |
| **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** |