**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**](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.

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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** | | |