



The Linden Centre Support Service Referral Form

It is our policy to contact the individual/family by letter within two working days of receiving this referral

Surname:	Forename:	Title:
Date of Birth:		
NHS No.:		
Address:		Telephone Numbers:
Post Code:		

Name and address of Referrer (please print)	Referrer's Role & Contact No:

Is the client happy for us to contact the GP after their initial appointment YES / NO


If Yes GP details:

Reason For Referral:
Bereaved Client: Yes / No *Living with Terminal or Life threatening illness* *Yes / No*

For Cascade referrals only:
Name of adult with parental responsibility: **School:**

www.trinityhospice.co.uk

The Trinity family of services:

-  Support/counselling for grief and loss
- In-Patient Unit
 - Complementary Therapy
- Day Therapy Unit
 - Learning and Research Centre
- Clinical Nurse Specialists
 - Lymphoedema Service



Low Moor Road, Bispham, Blackpool FY2 0BG Tel: 01253 595552

Please indicate the presenting problem :

Referrers signature:

date:

If self referral signed by admin :

SECTION BELOW TO BE COMPLETED BY LINDEN CENTRE ADMIN Date of first client contact :

Is the individual or family known to Trinity Hospice & Palliative Care Services :

Yes/No

PCT member :

Name of patient :

Relation to client:

What other professionals have been involved in their emotional/psychological support?

Names:

Role:

Contact details if known:

Is the client happy for us to contact them YES / NO

Tick type of support required

Spiritual needs

Counselling

Clinical Psychology

Home visit required?

Yes/No

Times and Days of initial appointment

Name of assessing counsellor