|  |  |
| --- | --- |
| **For Office Use Only**  *(Linden Centre/GDPR/New Documents 19.06.2018)*  **Living With Own/Carer/Bereaved:**  **Date of Referral:**  **Admin Signature:** | S:\Trinity Hospice\Brand\Trinity Hospice Templates\LOGOS\FOR USE ON INTERNAL DOCS\colour-trinity-logo-internal-documents.jpg |

**THE LINDEN CENTRE SUPPORT SERVICE REFERRAL FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Surname:** | | | **Title:** |  | **Ethnicity:** |
| **Forename(s)**  **Known as:** | | | | | **DoB:** |
| **Address:**  **Postcode:** | | **Home Telephone:**  **Mobile:**  **OK to leave a message: Y/N** | | | |
| **Referrers Name and Address:**  **Role:**  **Contact Telephone No:** | **Please Complete for CHILDREN Referrals Only:**  **Name of Adult with Parental Responsibility:**  **Relationship:**  **Address if different from above:**  **Telephone No:**  **School:** | | | | |
| **Living with own illness/Living with illness other person (Delete as appropriate)**  **Name and Relationship to Client (if appropriate):**  **Details of Illness:** | | | | | |
| **Name of Person Who Has Died:**  **Relationship to the Client:**  **Cause of Death: Place of Death:**  **Date of RIP:**  **Bereavement Support Groups Offered (post details to client): Y/N** | | | | | |
| **GP Details:** |  | | | | |

**Any amendments to above please enter details here:**

**I agree/do not agree for contact to be made to my GP**

**I confirm the information is correct and can be retained by the Linden Centre in the strictest confidence as it will only be used for the purposes for which it was provided. If any details change please advise in order that our records can be updated.**

**Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(**Adult with Parental Responsibility for Children)**

Issue Date: 19/06/18

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| --- |
| **Reasons for Accessing Our Service:** |

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| --- |
| **Have they had any contact with Trinity: Y/N**  **Details if known to Trinity:** |

|  |
| --- |
| **What other Professionals have been involved in their emotional/psychological support?**  **Name: Role:**  **Contact Details if known:**  **Is the Client happy for us to contact them: Y/N** |

**Please send to trinity.linden.centre@nhs.net**