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Referral Form (CONFIDENTIAL)

**Please complete this form as fully as possible as missing information may result in the referral being returned (\*Essential)**

**Referrer Details**

Date of referral: **\***

Name: **\***

Address and Postcode: **\***

Position:

Phone number: **\***

Is the client aware of referral? **\***

Can we leave messages on client’s phone? **\***

If the client is under 18, is the parent aware of the referral?

If the client is under 18, please give parents contact details:

**Client Details**

Name: **\***

Address and Postcode: **\***

Phone and mobile number: **\***

Email address:

Date of Birth: **\***

Ethnicity: **\***

Gender identity: **\***

Emergency contact name:

Emergency contacts number:

**Client’s Health Details**

GP Name:

GP Surgery:

Consultant:

Hospital:

Diagnosis and current treatment:

Additional health details:

**Reason for referral - Cancer or life shortening illness**

Is the referral for the patient: Y/N

If no, please state relationship to patient:

Details:

**Reason for Referral – Bereavement**

Is the bereavement related to a cancer/life shortening illness? Y/N

If no, was the bereavement sudden, traumatic, or unexpected?

Details:

Risk factors:

Any other services involved:

*Please return this form to: Therapy Services, CancerCare, Slynedales, Slyne Road, Lancaster, LA2 6ST Tel: 01524 381820 Email: tct@cancercare.org.uk*