**Referral Form (Confidential)**

*All details provided will be securely stored and used only in LBN offices. Lancashire BME Network takes your privacy seriously and any information you provide will be used only for the purpose of assessing your suitability to be referred to the Bereavement & Befriending service. Your information will be securely stored and will not be made available to any third parties. The information will be kept only for as long as necessary after which it will be securely destroyed.*

**Section A: Referrer Information**

|  |  |
| --- | --- |
| Name of Referring Organisation: |  |
| Name of Person Referring: |  |
| Role/Relationship to Client: |  |
| Telephone Number to Referrer: |  |
| Email Address of Referrer: |  |
| Date of Referral: |  |
| Reason for Referral:  *Please give a brief summary.* |  |
| How did you hear about our service? |  |

**Section B: Client Information**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name: |  | Last Name: |  |
| Preferred Name/Nickname: |  | Ethnicity: |  |
| Date of Birth: |  | Gender: |  |
| Full Address: |  | | |
| Email Address: |  | | |
| Daytime Contact Number: |  | Evening Contact Number: |  |
| Please indicate if there are any issues that we need to be aware of when making contact. |  | | |
| Does the individual have any additional needs i.e. communication/language, literacy, hearing or visual impairments?  *Please give details.* |  | | |
| Has the individual had any previous counselling? | No  Yes  If yes, please give details:  Agency:  Counsellor:  Dates and Duration: | | |
| Please give details of any known psychiatric history or any other information you think may be relevant.  *E.g. mental/physical health problems.* |  | | |

**Section C: Risk Assessment**

*To protect clients and service providers, and to ensure that the service is appropriate to the individual’s needs, please answer all questions fully.*

|  |  |  |
| --- | --- | --- |
| Issue/Concern: | *If you answer yes to any of the questions below, please provide further details in the next column.* | Notes:  *when, what happened, who was involved.* |
| Self-neglect | Yes  No  Unknown |  |
| Intentional self harm | Yes  No  Unknown |  |
| Abuse from others | Yes  No  Unknown |  |
| Violence from others | Yes  No  Unknown |  |
| Violence/aggression towards others | Yes  No  Unknown |  |
| Any other risk factors | Yes  No  Unknown |  |
| Sexually inappropriate behaviours | Yes  No  Unknown |  |
| Suicidal thoughts | Yes  No  Unknown |  |
| Suicide attempts | Yes  No  Unknown |  |
| Drug use/dependency | Yes  No  Unknown |  |
| Alcohol use/dependency | Yes  No  Unknown |  |

**Section D: Support Network/Agency Involvement Information**

*Please provide as much information as you can on any other therapeutic support the client may have received or is still receiving.*

|  |  |  |  |
| --- | --- | --- | --- |
| 1: Name of Organisation: |  | Contact Person: |  |
| Type of support provided: (counselling/therapy) |  | Is the support still being provided? |  |
| Contact Number: |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 2: Name of Organisation: |  | Contact Person: |  |
| Type of support provided: (counselling/therapy) |  | Is the support still being provided? |  |
| Contact Number: |  | | |

**Section E: Medication**

|  |  |
| --- | --- |
| Is the client on any medication?  *If yes, then please provide details.* |  |
| Any other comments: |  |

**Section F: Disclaimer**

|  |  |
| --- | --- |
| I understand that Lancashire BME Network will attempt to reach me 3 times. If they are unsuccessful in reaching me, this referral will be closed, and a new referral will need to be submitted. | Signed: |

**Please send this form, marked private and confidential to:**

# Lancashire BME Network Counselling Service,

# Lancashire BME Network,

**Suite 405,**

**Daisyfield Business Centre,**

**Appleby Street,**

**Blackburn,**

**BB1 3BL.**

**Telephone: 01254 392974 (in strict confidence – ask to speak to the Wellbeing Service Manager)**

**Email:** [**referral@lancashirebmenetwork.org.uk**](mailto:referral@lancashirebmenetwork.org.uk)

For LBN Office Use Only:

|  |  |
| --- | --- |
| Date Received: | Date Contacted: |
| Appointment Date: | Assessment Staff: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Allocated to in-house service: | | | Counsellor Name: | |
| Yes | No | | Start Date: | End Date: |
| If no, reason for not accepting. | | |  | |
| Referral made to another organisation? | | | Where? | |
| Yes | | No |

**Referral Criteria**

A referral may be appropriate:

* when the person is over 18 years of age
* when they are looking for short-term psychological therapy
* whenthey have some understanding that part of their problem/difficulty lies within themselves and how they are managing a situation

A referral will not be appropriate:

* when the person is actively self-harming/suicidal
* when they are physically or psychologically dependent upon substances such as alcohol or drugs which will interfere with their ability to reflect
* when the person is actively psychotic.

**Referral and Assessment Information for Agencies**

1. Anyone may be referred to the Lancashire BME Network Counselling Service who meets the criteria as detailed above.
2. You may refer by completing the referral form and sending to the office, either by post or by email. We also welcome self-referrals from your clients.

Who to Contact for Further Information?

Lancashire BME Network Counselling Service,

Lancashire BME Network,

# Suite 405,

**Daisyfield Business Centre,**

**Appleby Street,**

**Blackburn,**

**BB1 3BL.**

**Telephone: 01254 392974 (in strict confidence – ask to speak to the Wellbeing Service Manager)**

**Email:** [**referral@lancashirebmenetwork.org.uk**](mailto:referral@lancashirebmenetwork.org.uk)