

**A logo for a therapy center

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**Hamar Centre For Counselling and Wellbeing**

**REFERRAL FORM** (From Healthcare Professional)

The Hamar Centre offers patients individual or couples counselling regarding a diagnosis of cancer.

Patients need to meet the following criteria:

* Under the care of the Shrewsbury & Telford Hospital NHS Trust
* Aged 18 and over.
* Counselling must primarily be related to the patient’s illness.
* Being treated for or having last been treated within the past 18 months for cancer.
* Registered with a GP in the Shropshire, Telford, Wrekin, or Powys area.

If you have any questions around the referral process, please contact us on 01743 261035.

(Office hours Monday – Friday 9 am – 5pm)

**Please note we are not an emergency service and operate Monday- Friday 9am – 5 pm.**

**If you need to access more urgent support, please consider the following:**

* Request an urgent appointment with your GP.
* Contact the Mental Health Access Team Tel: 0808 196 4501
* Call NHS 111
* Attend your local A& E Department
* Contact the Samaritans Tel: 116 123 (Available: 24 hours / 365 days)

By submitting a referral, you consent for us to share information on our systems and agree to us contacting you / or the patient.

NB Please check that your patient has not already been referred for counselling at another service.

NB. For a referral to be processed please complete this form fully.

Thank -You

**TO AVOID DELAY – PLEASE ENSURE ALL OF THE FORM IS FILLED IN**

|  |  |
| --- | --- |
| Date of Referral |  |

**Referrer Information**

|  |  |
| --- | --- |
| Name |  |
| Role |  |
| Contact Email |  |
| Contact Number |  |

**Patient Information**

|  |  |
| --- | --- |
| Name |  |
| Address |  |
| Postcode |  |
| Date of birth |  |
| Hospital No |  |
| NHS Number (If possible) |  |
| Home Phone |  |
| Mobile Phone |  |
| Permission to leave a message (Yes or No) |  |
| Next of Kin (Name) |  |
| Relationship to patient |  |
| Contact number for Next of Kin |  |
| Other relevant medical conditions (e.g., asthma, insulin dependent diabetes, epilepsy etc) |  |

**GP Information**

|  |  |
| --- | --- |
| Name of GP and Practice Address |  |
| Practice phone number |  |

|  |  |
| --- | --- |
| Current Diagnosis & Date of diagnosis |  |
| Prognosis (if known) and please state if patient is aware of prognosis. |  |
| Current Treatment Plan |  |
| Any other medical conditions we need to be aware of e.g. diabetes, epilepsy. |  |

**Reason for Referral**

|  |
| --- |
|  |

**Additional Information** (e.g., is person aware of prognosis, any relevant medical, social or psychological factors)

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Is the person aware of the referral?  (Yes or no) |  |
| Has the patient used our services before?  (Yes or no) |  |

**Please Email this form to:** [**sath.hamarcentre@nhs.net**](mailto:sath.hamarcentre@nhs.net)

**Or via internal post to: The Hamar Centre, Royal Shrewsbury & Telford Trust, Mytton Oak Rd. SY3 8XQ**

**OFFICE INFORMATION ONLY**

|  |  |
| --- | --- |
| Date Referral received |  |
| Date Patient responded to contact letter. |  |
| Patient hasn’t responded within 2 weeks of contact |  |
| Date Assessment offered |  |
| Time between referral received and assessment appointment | 1 week    2 weeks    3 weeks    4 weeks |
| Patient’s preferred method of contact | Mobile Email    Landline |
| Previous Counselling Notes | YES NO |
| Allocated Counsellor |  |
| Outcome of assessment | Counselling Offered  Patient Did Not Attend  Patient no longer required counselling.  Patient referred to other service.  Patient declined offer & Reason: |
| Referrer aware of outcome of assessment | YES NO |
| Number of sessions attended. |  |
| Number of Sessions not attended (DNA) |  |
| Has discharge measure been given.  Date: | YES NO |
| Has discharge measure been returned.  Date: | YES NO |