COUNSELLING REFERRAL

Please complete **all shaded sections** and return to:
WELLBEING COUNSELLING SERVICE,
MACMILLAN WELLBEING CENTRE, MOORSIDE ROAD, DAVYHULME, M41 5SN
mft.macmillancentretrafford@nhs.net
TELEPHONE: 0161 746 2080

Referral criteria:	18 years or over Trafford resident or registered with Trafford GP

Date				Please indicate √ :			
CLIENT DETAILS				Bereavement		or	Cancer care	
				Face to face		or	Telephone	
Title				FOR OFFICE USE ONLY: Client ID code: Family/ carers known to service?			
Name							
Address				D. o. B.			
				Gender			
				Ethnicity			
Postcode				NHS number			
Contacts	Home no.			GP name GP address GP no.			
	Mobile no.						
	E-mail						
Interpreter needed?	yes	or	no	Home language			

REFERRER'S DETAILS			
Nature of referral- please indicate √ :			
Self		GP/ health professional	
Family/ carer (with permission)		Other	
Name		Name	
Relationship to client:		Address	
		Telephone	

Brief outline of reason for referral	
Any previous counselling?	
Medications	

Received by:	*Telephone*	*Face to face*	*Post*	*E-mail*	*Date:*