**Referral for Counselling or Art Psychotherapy**

***LJMC counselling and art psychotherapy is available for patients (and their families) receiving NHS treatment under the care of an MVCC oncologist.***

**Details of the person being referred**

Name: Date of birth:

Address:

Email:

male [ ]  female [ ]  patient [ ]  carer\*[ ]

*\*if carer: relationship to patient: patient’s name & DOB:*

Patient’s oncologist: hospital or NHS no:

Preferred contact phone number:

Alternative contact phone number:

If someone else answers the call, is it acceptable to leave a message with them? yes [ ]  no [ ]

GP name & address:

**Medical Details**

Cancer diagnosis:

Types of treatment (completed, planned or current with start/end dates):

**Referrer**

Referred by: position: phone:

Date of referral:

Form completed by (if different to above):

LJMC referrals only: referral made via helpline [ ]  drop-in [ ]

**LJMC use** Assessment booked: date: time: therapist:

other (withdrew/discontinued/referred on):

**Needs**

***Please ask the person you are referring these questions\*:***

How distressed have you been over the last week?

[ ] 1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10

No distress Extreme distress

What issues are you seeking help with?

[ ]  anxiety [ ]  depression [ ]  concerns about death [ ]  body image concerns

[ ]  uncertainty about the future [ ]  poor self-confidence [ ]  panic attacks [ ]  sleep problems

[ ]  relationship problems [ ]  fear of treatment ***other needs: please enter details in box below***

Have you had counselling at LJMC before? Yes [ ]  No [ ]  (if yes, please enter details in box below)

Are you currently having counselling with another service? Yes [ ]  No [ ]  (enter details below)

Have you been referred to any other counselling service? Yes [ ]  No [ ]  (enter details below)

*\*If you did not ask the person directly:*

*are these your judgements? [ ]  the person’s representative’s (e.g. relative) judgements? [ ]*

*have you directly gained consent from the person to be referred? Yes [ ]  No [ ]  (if no, enter reasons below)*

***Other information to be passed to counselling team: (e.g. person’s needs such as mobility or language needs, if holistic needs assessment done, other referrals, preferences)***