***ONE-TO-ONE / FAMILY / GROUP** (*Delete as appropriate)	
Reference No:	
Date Received at BHBA & Initial:	Date received by FST & Initial:
Given to (member of FST):	Date:
Date of First Contact:	Date of First Appointment:

BUTTERWICK HOSPICE CARE
FAMILY SUPPORT SERVICES

REFERRAL	RE-REFERRAL

WE CANNOT PROCESS ANY REFERRAL UNLESS ALL SECTIONS ARE COMPLETED

Referrers Name & Job Title:	**Referrers Contact Details:** to include postal address or email
Client NHS Number:	
Client Surname:	**Client First Name:**
Marital Status:	**Date of Birth:**
Address:	**Contact No** Home: Mobile:
Post Code:	**Ethnic Origin:**
G.P Surgery:	**G.P Telephone Number:**
Next of Kin:	**Relationship:**
Contact Tel No:	
Name of School / Organisation:	
Contact Name:	**Contact Tel No:**
Email:	
Is the client able to travel to the hospice? YES ☐ NO ☐	
Does the Client wish to be involved in any of the following: ONE to ONE/INDIVIDUAL COUNSELLING ☐ FAMILY SESSION ☐ GROUP SESSIONS ☐	
Availability of Client: Give details concerning the times when the client is available for counselling	

REFERRAL INFORMATION

Reason for Referral:

(If Applicable) Date of Bereavement:	Relationship to Client:

PLEASE SEND COMPLETED FORMS TO:
Head of Family Support/Family Support Administrator
Butterwick Hospice
Woodhouse Lane
Bishop Auckland
DL14 6JU

Tel: 01388 603003
Fax: 01388 603630

E: julietwilson@butterwick.org.uk (Head of FST)
E: p.hooks@butterwick.org.uk (FST Administrator)

Client Reference No:

FURTHER INFORMATION

Please document all dates and methods of contact, including messages left where applicable. Also document all contact made with other services professionals currently involved with the client including names and contact numbers.

DATE	INITIAL	NOTES