Charlies-Angel-Centre Foundation
Bereavement Counselling Referral Form

Name

First Name Last Name

Address

Street Address

Street Address Line 2

City

Postal / Zip Code

Phone Number

Area Code Phone Number

Email

Gp Details

Would you like to be contacted by Email or Telephone?

Please give brief details of why you wish to access this service which counseling service and when your loss occurred

Where did you hear about our service?

Please included days and times you are available for counseling sessions, we are open 7days a week including evenings

Would you prefer a male or female counselor?

Have you ever had counseling before? If yes, please outline your experience

Pre-assessment

The aim of this form is to help the counselor who you will be assigned to understand whether you have any previous mental-health history and whether any health considerations need to be in place during your sessions.

- ☐ Diabetes
- ☐ Epilepsy
- ☐ Respiratory condition eg asthma
- ☐ Physical disability such as impaired sight, hearing mobility etc
- ☐ Eating disorders
- ☐ Stress
- ☐ Mood disorders (such as depression or bipolar disorder)
- ☐ Anxiety disorders
- ☐ Personality disorders
- ☐ Trauma-related disorders (such as post-traumatic stressdisorder)
- ☐ Psychotic disorders (such as schizophrenia)
- ☐ Substance abuse disorders
- ☐ Violent or aggressive outbursts

If you have ticked any of the above please give details here

Signature _____

This service is appropriate for: (counseling service)
Please consider the eligibility criteria below before completing this form.
Bereavement / loss
The remit of this service is to support individuals experiencing ‘life issues’ such as those detailed above.

Counseling is a free service and our counselors are all volunteers, whilst we appreciate that emergencies do happen, when undertaking counseling we require commitment from clients to attend their sessions where possible

Confidentiality
The content of the sessions are confidential to counselor and client.
I will need to discuss my work with my supervisor and peer supervision group.
I will use your first name but not use any other identifying details about you. On very rare occasions if we discover there is a need to communicate with other professionals, this will only happen by first seeking your permission and knowledge of what is going to be discussed.
I make brief notes after each session; this helps me monitor my work. You will not be identified from these records and they are securely stored.
I work in line with the ICO Information Commissioners Office guidance.
No other person has access to them. The possible exceptions to this non sharing code are:

If I think you are at risk of giving or receiving serious harm from self or others
If I am required to do so by a UK court of law
If I believe you will cause serious physical harm to yourself or another person then I will not be able to retain confidentiality and will be forced to inform my supervisor and your doctor. Confidentiality would be broken in the event of a breach of national security..

Please sign and return this form either by way of email or post

Email-Charliesangelcentre@hotmail.com

Charlies-Angel-Centre Foundation

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Parkside Lane.

Ls115sf