

Charlies-Angel-Centre Foundation Bereavement Counselling Referral Form



When submitting a form for bereavement counselling, please consider the commitment this takes and if you are ready for counselling, if you are not sure, you can discuss this with us, we are here to help

Name

Address & Postcode

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 counselling service and when your loss occurred

Where did you hear about our service?

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

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

Pre-assessment

The aim of this form is to help the counsellor 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 e.g. 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 stress disorder)

Psychotic disorders (such as schizophrenia)

Substance abuse disorders

Violent or aggressive outbursts

None

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

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Charlie's Angel Centre Foundation Bereavement Counselling Equal Opportunities Monitoring Form

Charlie's Angel Centre Foundation is committed to ensuring that all service users are treated equally, without discrimination on the grounds of gender, sexual orientation, marital or civil partner status, gender reassignment, race, colour, nationality, ethnic or national origin, religion or belief, disability or age. This form is intended to help us maintain equal opportunities best practice and identify barriers to equality and diversity.

The information on this form will be used for monitoring purposes only and will play no part in the counselling assessment process. All questions are optional. You are not obliged to answer any of these questions but the more information you supply, the more effective our monitoring will be. All information supplied will be treated in the strictest confidence.

Gender.

Male Female

Age Group.

16-24

25-40

41-55

56-65

Over 65

Do you live and work in a gender other than assigned at birth?

Yes

No

Prefer not to say

Please select the option which best describes your sexuality

Lesbian / Gay

Heterosexual

Bisexual

Asexual

Other

Prefer not to say

The Equality Act 2010 protects disabled people. Do you consider yourself to have a disability?

Yes

No

Prefer not to say

If you ticked yes, please state the impairment(s) which apply to you

Physical Impairment

Sensory Impairment

Mental Health Condition

Learning Disability/Difficulty

Long-Standing illness

Other

How would you describe your religion or belief?

Atheism
Islam
Buddhism
Christianity
Hinduism
Sikhism
Other
Prefer not to say

I would describe my ethnic origin as:

Asian
Bangladeshi
Indian
Pakistani
Other
Black
Black African
Caribbean
Other

White

White British
Irish
other

mixed

Asian & White Caribbean & White
Black African & White Black
Caribbean & White
Other

Other Ethnic Group

Chinese
Other ethnic group
I do not wish to disclose my ethnic origin

Thank you for taking the time to complete this form

Signature **Date**

Registered Charity Number 1172233

Please sign and return this form either by way of email or post
Email-infocharliesangelcentre@gmail.com
Charlies-Angel-Centre Foundation 6B Ashbrooke Park.
Parkside Lane.
Ls115sf