## Bereavement & Befriending Service Referral Form (Confidential)

*All details provided will be securely stored and used only in LBN offices. Lancashire BME Network takes your privacy seriously and any information you provide will be used only for the purpose of assessing your suitability to be referred to the Bereavement & Befriending service. Your information will be securely stored and will not be made available to any third parties. The information will be kept only for as long as necessary after which it will be securely destroyed.*

**Referrer details**

|  |  |
| --- | --- |
| **Name of referring organisation** *( if applicable)* |  |
| **Name of person referring** |  |
| **Role/relationship to client** |  |
| **Tel number** |  |
| **Email address** |  |
| **Date of referral** |  |
| **Reason for referral** |  |
| **How did you hear about the service?** |  |

|  |  |
| --- | --- |
| **Is there any history of risk taking behaviour;**  **e.g. drugs, alcohol, sexually inappropriate behaviour, suicidal thought, violence etc.** |  |
| **Are any of these behaviours recent / current?** |  |

**Service user details:**

|  |  |  |  |
| --- | --- | --- | --- |
| **First name** |  | **Last name:** |  |
| **Preferred name/ Nickname** |  |  |  |
| **Date of birth/age** |  | **Gender:** |  |
| **Address** |  | | |
| **Phone number daytime** |  | | |
| **Phone number evening** |  | | |
| *Please indicate if there is any confidentiality issues around contact.* | | | |

**Support network/agency involvement information:** *Please provide as much information as you can on any other therapeutic support the client may have received or is still receiving.*

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Name of organisation** |  | **Contact person** |  |
| **Type of support provided**  **(counselling/therapy)** |  | **Is the support still being provided** |  |
| **Contact number** |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
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| **Contact number** |  | | |

**Medication:**

|  |  |
| --- | --- |
| **Is the client on any medication***? If yes then please provide details* |  |
| **Any other comments** |  |

**Please send this form, marked private and confidential to:**

# Lancashire BME Network Bereavement & Befriending Service

# Lancashire BME Network

**Suite 412**

**Daisyfield Business Centre**

**Appleby Street**

**Blackburn**

**BB1 3BL**

**Telephone: 01254 392974 (in strict confidence)**

**Email:** [**office@lancashirebmenetwork.org.uk**](mailto:office@lancashirebmenetwork.org.uk)

**For Office Use Only**

|  |  |
| --- | --- |
| Date Received | Date Contacted |
| Appointment Date | Assessment Staff |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Allocated to In-house Service   |  |  | | --- | --- | | Yes | No |   If No, reason for not accepting  Referral made?   |  |  | | --- | --- | | Yes | No |   Where? | Counsellor Name:   |  | | --- | | Start date | | End Date | |

**Lancashire BME Network Bereavement & Befriending Service – Referral Information**

# Referral Criteria

A referral may be appropriate:

* when the person is over 18 years of age
* when they are looking for short-term psychological therapy
* whenthey have some understanding that part of their problem/difficulty lies within themselves and how they are managing a situation

A referral will not be appropriate

* when the person is actively self-harming/suicidal
* when they are physically or psychologically dependent upon substances such as alcohol or drugs which will interfere with their ability to reflect
* when the person is actively psychotic.

Referral and assessment information for agencies

1. Anyone may be referred to the Lancashire BME Network Bereavement & Befriending Service who meets the criteria as detailed above.
2. You may refer by completing the referral form and sending to the office, either by post or by email. We also welcome self-referrals from your clients.

***Who to Contact for Further Information*?**

# Lancashire BME Network Bereavement & Befriending Service

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