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| **CONFIDENTIAL** |
| Today’s date:  | CLIENT REQUESTED SUPPORT: ❑YES❑ NO |
| client INFORMATION |
| Client’s forename/s:  | Client’s Surname: |
| Birth date: | Age:  | Gender:❑ Male ❑ Female ❑ Transgender ❑ Other |
| Address: |
|  |
|  |
|  | Post Code: |
| Home phone no: | Mobile: |
| Relationship to deceased:  |
| Reason for referral: Any previous experience of counselling?Any previous psychiatric diagnosis, mental health treatment or special needs?Any episode of suicidal thoughts or any attempts made?**Service needs:**Counselling ❑ Group Support ❑ Complementary Therapy ❑ Advice and Information ❑ Referred to service area: Date referred: |
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| DECEASED INFORMATION |
| Name: | Date of death: |
| Circumstances of death: |
| Address: |
|  | Postcode: |
| Referrer details |
| Name: |
| Address: |
|  | Postcode: |
| Relationship to client: |
| Telephone no.:  | Email: |
| GP Details if different from above: |
| Name: |
| Address: |
|  | Postcode: |
| Telephone no.: | Email: |
| Please indicate Client’s Ethnicity |
| ❑ Asian British Bangladeshi ❑ Asian British Indian❑ Asian British Pakistani❑ White & Asian  | ❑ Asian British❑ Other Asian Background❑ Black British African❑ Black British Caribbean | ❑ Black British Somali ❑ White and Black African❑ White and Black Caribbean ❑ Other Black Background❑ Black British ❑ Other Mixed background  | ❑ White British❑ White Irish❑White Lithuanian❑ White Polish❑ White Romanian❑White Bulgarian | ❑ Gypsy/Traveler❑Other White background❑ Chinese❑ Vietnamese❑ Other❑Not Known❑ Not Asked |
| PLEASE POST or EMAIL TO: |
| **ADDRESS: 655 Barking Road, London, E13 9EX****TEL: 0207 510 1081/0207 510 4268****EMAIL:** **referral@mithn.org.uk** |
| **FOR BEREAVEMENT SERVICE USE ONLY:** LOGGED DATE: */ /* INITIAL ASSESSMENT: DATE: */ /*ACTIONED: VOLUNTEER ASSIGNED: DATE*: / /**Referred to Complementary Therapy*  DATE: */ /**Referred to Advice and information*  DATE: */ /**Referred to group support*  DATE: */ /* |