#

|  |
| --- |
| **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 ❑ Prefer not to say |
| Address: |
|  |
|  |
|  | Post Code: |
| Primary Contact Number: | Email address: |
| 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 ❑ Advice and Information ❑ Early Bereavement Support (Covid-19)Referred to service area: Date referred: |
|  |
| 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 INDICATE CLIENT’S RELIGION** |
| ❑ Buddhist❑ Sikh | ❑ Christianity❑ Muslim | ❑ Hindu❑ Other | ❑ Jewish❑ Prefer not to say | ❑ No Affiliated Religion Background |
| **PLEASE INDICATE CLIENT’S DISABILITY** |
| ❑ Deafness /partial loss of hearing❑ Blindness /partial loss of sight | ❑ Learning Disability❑ Learning Difficulty  | ❑ Physical Disability❑ Developmental disability Other | ❑ Long Term Illness❑ Other | ❑ Prefer not to say❑ No |
| **PLEASE INDICATE CLIENT’S SEXUALITY** |
| ❑ Heterosexual | ❑ Bisexual | ❑ Gay | ❑ Lesbian | ❑ Other❑ Prefer not to say |
| **PLEASE INDICATE CLIENT’S PREGNANCY CARER?** |
| ❑ Pregnant | ❑ On Maternity Leave | ❑ Returning from Maternity Leave | ❑ Other | ❑ Yes❑ No |
| 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: Initial Assessment: Volunteer assigned: Referred to Advice and information: Referred to group support:  |