

STRESS Management & COUNSELLING /

helping Hands SERVICE

**REFERRAL FORM**

Please be aware that the employee may be contacted by a member of the Helping Hands Service prior to any appointment with the Counselling team.

**For School Referrals please complete Appendix A in order for this form to be processed.**

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| --- | --- | --- | --- |
| **DATE REFERRAL RECEIVED**: |  | **SMAC CODE:** |  |
| **FOR COMPLETION** | | | |
| **Name:** |  | | |
| **Employee number:** |  | | |
| **Title:** |  | | |
| **Address:**  **(Please advise if you do not want to be contacted by letter.)** |  | | |
| **Home Telephone Number:** |  | | |
| **Mobile Telephone Number:** |  | | |
| **Date of Birth:** |  | | |
| **Job Title:** |  | | |
| **Section:** |  | | |
| **Directorate:** |  | | |
| **School (if applicable):** |  | | |
| **Date Referral submitted:** |  | | |
| **WHAT IS THE PURPOSE OF THIS REFERRAL:** | | | |
|  | | | |
| **WHY DO YOU WANT OUR SERVICE TO BECOME INVOLVED**  **AT THIS PARTICULAR TIME:** | | | |
|  | | | |
| **IS THERE ANY ADDITIONAL INFORMATION**  **YOU WOULD LIKE TO PROVIDE?** | | | |
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| **REFERRAL DETAILS:**  If this is a Self-Referral, **YOU DO NOT NEED** to complete this part of the Form | | |
| **Date of Referral:** |  | |
| **Completed by: (print or type name)** |  | |
| **Telephone Number:** |  | |
| **Job Title:** |  | |
| **Place of Work:** |  | |
| **Has the employee consented to this Counselling Referral?**  (We advise that you make the employee aware in writing that you have referred them, for counselling via letter or e-mail.  Please gain their consent before completing the referral form) | |  |
| **If the employee has been absent from work due to sickness, please provide the start date of their absence:** | |  |
| **Are there any Risk Management Factors to be considered?** | |  |
| **If yes, please give specific details:** | |  |
| **DO YOU HAVE ANY CONCERNS REGARDING ANY OF THE FOLLOWING:** | | |
| Self-Harm Yes  No  Harming Others Yes  No  Substance Misuse Yes  No  Excessive Worries Yes  No  Suicidal Thoughts Yes  No | | |
| **AN INCOMPLETE REFERRAL FORM MAY CAUSE DELAY IN SERVICE** | | |
| Please note that the Stress Management & Counselling Service  will not take on Medical or Diagnostic responsibility, which will remain the employee’s General Practitioner | | |

**PLEASE RETURN THIS FORM TO:**

Stress Management and Counselling Service, Room 151, The Guildhall, Swansea, SA1 4PE; or e-mail [Confidential.Counselling@swansea.gov.uk](mailto:Confidential.Counselling@swansea.gov.uk)