

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.**

|  |  |  |  |
| --- | --- | --- | --- |
| **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?** |
|       |

|  |
| --- |
| **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 Servicewill 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