Woodlands Hospice Charitable Trust

Referral

Family Support Services

*Name: _____ (Patient / Relative / Close Friend / Carer / Child)

Address: _____

_____ _____ Post Code: _____

Telephone No: _____

*Date of Birth: _____

*Ethnicity: _____ *Religion/Beliefs: _____

GP Name: _____ GP Telephone No: _____

GP Address: _____

_____ Post Code: _____

*Patient Name: _____ *Diagnosis: Cancer / Non-cancer

*Patients NHS No: _____ CCG:_____

Reason for Referral:

Consent given YES / NO

*Referred By: _____ From: _____

Telephone No: _____

*Date of Referral: _____

Date Referral Received: _____ Allocated to: _____

- Family Support Bereavement Support Pastoral Support Counselling
- New / Re-access

*Date of Initial Contact: _____ Date of 1st Appointment: _____