**ALL SERVICES ARE PROVIDED FREE OF CHARGE**

Please complete the following information for the person being referred and return to saralee.trust@nhs.net

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Address****Postcode** |  |
| **DoB** |  |
| **Phone** |  |
| **Mobile** |  | **Email** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Next of Kin**  |  | **GP** |  |
| **Relationship** |  | **Other Primary Healthcare contacts** (DN, Mac etc) |
| **Contact No** |  |

|  |  |  |
| --- | --- | --- |
| **Person being referred** | **Referral for** | **Preferred location** |
| [ ]  Patient [ ]  Family Member [ ]  Carer [ ]  Partner [ ]  Other | Option 1:[ ]  SLT Practitioner to assess and refer to the most beneficial services | [ ]  Hastings[ ]  Bexhill[ ]  Rye[ ]  Home Visit\*\*\*[ ]  Telephone/Zoom |
| Option 2: Select one or more of the following:[ ]  Counselling [ ]  Complementary Therapy\*[ ]  CBT [ ]  Group Support Activities\*\* |

*\* The Trust provides a range of complementary therapies including Acupuncture, Aromatherapy, Couples Massage, Massage, Reflexology, Reiki, Shiatsu*

*\*\* Our range of specialist group support activities and events include Yoga (beginner and maintenance), Mindfulness, Look Good Feel Better workshops, Healthy Cooking classes and,Support Groups, including nature based therapies*

*\*\*\* If a home visit is required, the Home Visit Needs/Risk Assessment Form must also be completed.*

**If the referral is for a patient, please also complete the following:**

|  |  |  |
| --- | --- | --- |
| **Diagnosis** |  | **Is the patient aware of diagnosis?** [ ]  |
| **NHS No** |  | **Does the patient have a DNAR?** [ ]  |
| Using Layman’s terms, please provide a **brief clinical summary** |
|  |

|  |
| --- |
| **Please provide any other information** that might be relevant for those communicating with, or providing therapy to, the person above, including disabilities, DVTs, allergies and potential risks |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer’s Name** |  | **Contact No** |  |
| **Role** |  | **E-mail** |  |
| **Organisation** |  | **Date** |  |

**Next steps:** On receipt of a completed referral form we will do the following:

* Confirm receipt to you using the email address provided.
* Contact the person being referred (usually within 3 days), provide them with information on our services and offer a first appointment within 3 weeks of referral (subject to their availability and ours).
* Patients being referred for complementary therapies will be offered an initial block of 6 treatments, family/carers will be offered an initial block of 3 treatments. The number of counselling sessions provided will be determined on a case by case basis. Most groups run for a set number of sessions.