



GP Referral Form THE DROP – IN Bereavement centre

GP Name:

(PLEASE STAMP WITH SURGERY STAMP OR WHERE POSSIBLE COMPLETE FULL DETAILS OF SURGERY)

Address of Surgery:

Date of referral: ____ / ____ / ____

Reason for referral:

187 Grange Road

Plaistow

London

E13 0HA

Tel: 020 7511 6444

Services the centre offers... Please tick appropriate box.

- Bereavement counselling
- Support Groups
- Complimentary Therapy Sessions
- Accessing information on Bereavement
- Social Activities (Yogo for Grief/Art Therapy/Tai Chi)
- Outings to Places of interest/Fundraising Events
- Will advisory Information/Life Coaching

CLIENTS DETAILS TO BE COMPLETED BY GP OR PRACTICE MANAGER

Clients name:

Date of birth ____ / ____ / ____ Male Female (please tick)

Address:

Ethnicity:

Telephone/Mobile:

Date of death of Spouse/Partner/Family member (please state): ____ / ____ / ____

Has client accessed previous counselling and if so, please give details below Yes No

FURTHER INFORMATION IF CLIENT HAS ACCESSED PSYCHOLOGICAL TALKING THERAPIES, MENTAL HEALTH COUNSELLING, IF SO, PLEASE ATTACH A BRIEF HISTORY and how many weeks of counselling.

Any other relevant information?

Please continue on back of sheet if necessary

Is the patient on any medication which the counsellor should know about? (Please list below)



HOW TO GET THERE

FROM CANNING TOWN BUS STATION:

* All Buses towards East Ham or Romford
5/69/115/276/300/474

FROM EAST HAM BARKING DIRECTION:

5/69/115/276/300/474

FROM STRATFORD or PLAISTOW STATION: 69