brainstrust
the brain cancer people

brainstrust's counselling service

Referral form

Referred by:

Name:

Age range (please circle):	18–25	26–44	45–6	60+

Patient ☐ **Carer** ☐

Name and contact number of GP:

Lives with others ☐ **Lives alone** ☐

Children:

Name	Age	Name	Age	Name	Age
Name	Age	Name	Age	Name	Age

Employment

Concern – *Please underline the appropriate category (if more than 1, also circle the predominant issue):*

Depression (1)	**Anxiety (2)**	**Stress (3)**	**Relationship (4)**	**Anger (5)**	**Coping with Bereavement (6)**

Other:

Background/Brief history:
(Please include any medication you are on and whether you have had previous psychological support)

What do you hope to gain from counselling?

You might also find our website useful for further information about counselling: www.brainstrust.org.uk

Contact details

Email address

Phone number

OK to leave message (please circle):	YES	NO

brainstrust is a registered charity in England and Wales (1114634), and Scotland (SC044642)