**BEREAVEMENT REFERRAL FORM**

**SECTION ONE** – REFERRER INFORMATION:

|  |  |
| --- | --- |
| Self/Other? | Self Other  If other, please state Name/Position/Relationship: |
| Consent: | Has bereaved person given permission to make this call? YES  NO |

**SECTION TWO** – BEREAVED PERSON/CLIENT INFORMATION:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Bereaved Person/Client: | |  | | |
| NHS Number: | |  | | |
| GP Practice/GP Address (NEL ONLY) | |  | | |
| Date of Birth of Bereaved Person/Client: | |  | | |
| //Ethnicity: |  | | Religion: |  |
| Bereaved Person/Client’s Main Spoken Language: | |  | | |
| Address (inc. post code): | |  | | |
| Contact Number(s): | | Daytime:  Evening: | | |
| Is there anyone else in the house that is aware you have contacted NEL Bereavement Support Services? | | YES NO | | |
| Is it ok to leave a message on your answer phone? | | YES NO | | |
| Are you available during the daytime and evenings? | | Daytime only  Evening only  Both | | |

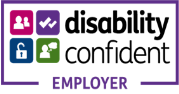
**SECTION THREE** – BEREAVEMENT INFORMATION:

|  |  |
| --- | --- |
| Relevant Information (free text in space provided below): | |
|  | |
| Was the deceased receiving support from any of the following services: | Macmillan  The Hospice  The Haven  Lymphoedema Service |

**SECTION FOUR** – VALIDATION:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Referral Completed By: | | | | |
| Name: |  | | Contact Number: |  |
| Date: |  | | Time: |  |
| Position Held: | |  | | |
| Resolved over the telephone: | | YES  NO  (if no, then signature will be required) | | |

**Please email completed Referral Form to:** [CPG.specialistpalliativecareservices@nhs.net](mailto:CPG.specialistpalliativecareservices@nhs.net)

Or telephone: 01472 250623 for any queries 

NEL Bereavement Support Services Published: 20.6.17 Version: 1.4 Review Date: June 2018