**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

Or telephone: 01472 250623 for any queries 

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