SPRINGHILL HOSPICE
Broad Lane, Rochdale, OL16 4PZ
Tel: 01706 649920 Fax: 01706 644943 Email: hmrccg.liaison@nhs.net

BEREAVEMENT SERVICE REFERRAL FORM

We accept referrals for adults bereaved by the loss of someone with a diagnosed life-limiting illness
****Please complete all sections. Incomplete referrals will be returned to the referrer****

Has the client consented to this referral? Yes □ No □
Please note this referral will only be processed if the client is aware and has given consent

Client details:

Surname:	Date of Birth:
First name:	Sex:
Address:	Ethnicity:
	Language:
Postcode:	Marital status: Title:
Landline No: **Consent to leave a message Yes □ No □**	Is the client housebound: Yes ☐ No ☐
Mobile No: **Consent to leave a message Yes □ No □**	Does the client live alone: Yes ☐ No ☐

Next of Kin details:

Surname	Address:
First name:	
	Postcode:
Relationship:	Tel:

Referrer:

GP ☐ Self ☐ Other ☐ (please specify)

GP

GP name:
Address:

Tel:
Fax:

Other services involved:

Other (please specify)
Tel:

Other (please specify)
Tel:

Other (please specify)

Nature of Bereavement

We accept referrals for adults bereaved by the loss of someone with a diagnosed life-limiting illness

Date of Loss:

Relationship to the client:

Circumstances of death. Please give as much detail as possible:

Bereavement is a normal process and does not usually require intervention. Why do you feel this would be helpful for this client?

Mental Health

****Please note: If this client has a diagnosed mental health illness, or has multiple issues in addition to bereavement; it is more appropriate they be referred to IAPT/Thinking Ahead or another specialist psychotherapy service.**

Is the client under care of a psychiatrist: currently **Yes □ No □ or previously Yes □ No □
Name: Tel:
Address:

Are mental health services involved? ** Yes □ No □
(please give as much detail as possible along with contact details)

Any other psychological history? Previous counselling? Yes □ No □
(please give as much detail as possible)

Risk

Risk of self-harm? Yes □ No □
(please give as much detail as possible)
Risk to others? Yes □ No □

Medication

Is patient/client prescribed medication for anxiety and/or depression?
Please list medication, start date and dose:

Person completing referral: Print Name: Signature:	**Designation:** Tel: Date: