**Nightingale House Hospice Bereavement Support Referral Form**

If urgent advice is needed, please contact **01978 316800** (Mon-Fri 8.30am-4.30pm)

Email completed form to: [nightingalehousereferrals@wales.nhs.uk](mailto:nightingalehousereferrals@wales.nhs.uk)

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| **Details of person completing this referral form:** |  | | | **Relationship to the referred:** | |  | | | | |
| **Contact details:** |  | | | **Email address:** | |  | | | | |
| **Details Of Person Being Referred** | | | | | | | | | | |
| **Name:** |  | | **Date of Birth:** |  | | | **Ethnicity:** | | |  |
| **Home Address:** |  | | | | | | **Postcode:** | | |  |
| **Email address:** |  | | | | | | **Preferred language:** | | |  |
| **Phone - Home:** |  | | **GP Name and Surgery details:** |  | | | | | | |
| **Phone - Mobile:** |  | |
| **Will you be able to attend onsite appointments?** | Y/N Please provide details if you are unable to attend onsite appointments: | | | | | | | | | |
| **What type of bereavement support is needed?** | Emotional | Religious/ Spiritual/  Beliefs | | Financial | Practical | | | | Other – Please explain | |
|  |  | |  |  | | | |  | |
| **If referral for a child (under 18). please provide Parent/Guardian details:** | | | **Relationship to the child:** | | | | | **Parent/Guardian contact number:** | | |
|  | | |  | | | | |  | | |
| **Is the child aware of this referral?** | | | Y/N  Have they consented to the referral? Y/N | | | | | | | |
| **Childs educational setting: Address, Contact Name and Number:** | | |  | | | | | | | |

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| **Name of Deceased:** |  | **Relationship to the referred:** |  | **Age:** |  |
| **Were they known to hospice services?** | | **Y/N** | | | |
| **Place of death:** | | Home  Hospital  Hospice Other | | | **Date of death:** |
| **Cause of death and any significant details surrounding the death e.g., expected, sudden or traumatic:** | |  | | |  |

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| **Please indicate which service(s) are required:** | Adult Bereavement  Bereavement  Pre-Bereavement |
| **Please indicate which type of support you feel would be beneficial**  Group Support ☐ Drop-in Support Group  Information and signposting  1:1 support  to reduce social isolation |
| **Please describe any other support for your bereavement that may be helpful:** |  |
| **Are you currently accessing any program of counselling, therapy or mental health services?** | services for adults  people’s counselling service  Services support (Social Worker, Family Support Worker etc. |
| **If yes lease provide contact details of provider:** |  |
|  | **For child referrals please describe and tick boxes as appropriate:** |

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| **Please describe any other significant losses/events/risks or previous trauma.** | Domestic Violence  after child or experienced separation  Parent has mental health diagnosis  experienced abuse or neglect  A member of their household is in prison.  **For adults please describe:** |
| **Please describe your current support network- supportive people in the family, community, or professionals and how they support you:** |  |
| **Reason for referral:**  **Please describe any problems and challenges you are experiencing which you believe are linked to your grief:** |  |

To be completed by NHH staff:

|  |  |
| --- | --- |
| Referral Date: |  |
| Date of NHH Contact: |  |
| Form completed by: |  |
| Triaged by: |  |
| Triage Outcome |  |