**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

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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  |  |