**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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| **Name of person completing this referral form:** |  | | | | **Relationship to the referred:** | |  | | | | |
| **Telephone details of referrer above:** |  | | | | **Email address of referrer:** | |  | | | | |
| **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 young person (under 18). Please provide Parent/Guardian details:** | | | **Relationship to the child:** | | | | | | **Parent/Guardian contact number:** | | |
|  | | |  | | | | | |  | | |
| **Is the young person 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?**  **(Please note Nightingale House Hospice is not connected to Hospice at Home)** | | **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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| **Area of service required: (Please note we can only accept anticipatory loss referrals where patient is accessing services).** | **Adult Bereavement  Child Bereavement  Pre-Bereavement** |
| **Please indicate which service(s) are of interest:** | **Please indicate which type of support you feel would be beneficial:**  **Group Support  Adult Bereavement Drop-In Support**  **Information and signposting  1:1 support**  **Support to reduce social isolation** |
| **Are you currently accessing any program of counselling, therapy or mental health services?** | **CAHMS  Counselling services for adults**  **Young people’s counselling service**  **Social Services support (Social Worker, Family Support Worker etc.)** |
| **If yes, please provide contact details of provider:** |  |
| **Please describe any other significant losses/events/risks or previous trauma.** | **For child referrals please describe and tick boxes as appropriate:**  **Domestic Violence**  **Looked after child or experienced separation**  **Parent has mental health diagnosis**  **Has experienced abuse or neglect**  **A member of their household is in prison.**  **For adults please describe:** |
| **Reason for referral:**  **Please describe any problems and challenges you are experiencing which you believe are linked to your grief:** |  |
| **Please describe your current support network-family, community, or professionals and how they support you:** |  |

**To be completed by NHH staff:**

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