**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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| **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:**

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