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| FOR OFFICE USE ONLY | CASE NO: |
|---------------------|----------|

**REFERRER TO COMPLETE**

|  |   |
|--|---|
| Date of Referral:  | Written/Phone/Email *(delete as appropriate)  |
| Name of child/young person:                              | Date of birth:  |
| Address:   | Refereer's Name & Title:<br><br>Referrer's tel. no.:                                |
| Name of parent/carer:                                    | Referrer's email address:   |
| Contact details of parent/carer if different from above: | Referrer's address:   |
| Contact tel. no.:  | Parental Consent Obtained: YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Name of GP and Surgery:                                  |   |

| PRE-BEREAVEMENT SUPPORT   | POST-BEREAVEMENT SUPPORT   |
|---|--|
| Relationship of the person who is ill:  | Relationship of the person who has died:   |
| Diagnosis:  | Cause of death:  |
| Prognosis:  | Date of death:   |
| Is the person who is ill a patient at Foyle Hospice or known to the Home Care Team?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | Was the person who died a patient at Foyle Hospice or known to the Home Care Team?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |

| RELIGION                                  |   |
|---|---|
| Religious Belief:<br>*(please select one) | Roman Catholic <input type="checkbox"/> Protestant <input type="checkbox"/> |
|   | If other please give details:   |
|   | Not applicable: <input type="checkbox"/>                                    |



**RELEVANT DETAILS**

**Other services involved (please note this section must be completed)**

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**Past mental health history**

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**Any known risks**

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**Reason for referral now**

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**Family Background/Further Information**

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**Please clearly mark  
'PRIVATE & CONFIDENTIAL'  
And return to:**

**Michelle Kosky  
Children & Young Person's Facilitator  
Foyle Hospice  
61 Culmore Road  
L'Derry, BT48 8JE**

**FOR OFFICE USE ONLY**

|                     |                             |
|---------------------|-----------------------------|
| Supporter:          | Date referred to Supporter: |
| Date of assessment: | Date contacted client:      |
| First session:      | Action                      |
| Last session:       | GP letter sent:             |
| No. of sessions:    | GP end letter sent:         |