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

**REFERRER TO COMPLETE:**

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| Date of Referral: | Written/Phone/Email \*(delete as appropriate) |
| Name of child/young person: | Referrer’s Name, Title and Telephone:Telephone No: |
| Date of Birth: |
| Address: | Referrer’s Address: |
| Name of Parent/Carer: | Referrer’s Email Address: |
| Contact Details of parent/carer if different from above: | Referrer’s Address: |
| Contact Telephone No: | Parent Consent Obtained: Yes □ No □ |
| Name of GP: | Name of Surgery: |

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| **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 Home Care Team?Yes □ No □ | Was the person who is ill a patient at Foyle Hospice or known to Home Care Team?Yes □ No □ |

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| **Religion** |  |
|  | Catholic □ Protestant □ |
| If Other please give details: |
| Not Applicable □ |

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| **Relevant Details** |

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| **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 the Referral Now:** |
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| **Family Background/Further Information:** |
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| --- | --- |
| Please Clearly Mark:**‘PRIVATE AND CONFIDENTIAL’**And return to: | Michelle KoskyChildren and Young Person’s FacilitatorFoyle Hospice61 Culmore RoadDerry/Londonderry, BT48 8JETelephone: (028) 7135 1010 |

|  |  |
| --- | --- |
| 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: |

**For Office Use Only**

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