HEALING HEARTS

Children and Young Person's Bereavement Support Service (4-16yrs)

FOR OFFICE USE ONLY	CASE NO:

REFERRER TO COMPLETE:

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

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 ☐

Religion	
	Catholic ☐ Protestant ☐
	If Other please give details:
	Not Applicable ☐

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Foyle Hospice
Together we care

Relevant Details

Other Services Involved: *(please note this section must be completed)*

Past Mental Health History:

Any Known Risks:

Reason for the Referral Now:

Family Background/Further Information:

Please Clearly Mark: **'PRIVATE AND CONFIDENTIAL'** And return to:	Michelle Kosky Children and Young Person's Facilitator Foyle Hospice 61 Culmore Road Derry/Londonderry, BT48 8JE Telephone: (028) 7135 1010

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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:

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