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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: | Referrer’s Name, Title and Telephone: |
| Date of Birth: |
| Address: | Referrer’s Address: |
| Name of Parent or Carer & Email address: | 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 GP: |  Name of GP Surgery: |
| SCHOOL INFORMATION |  |
| Name of contact person in school: |  Information of contact person in school: Telephone: Email: |
| Name and Address of School: |  |
| **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 □ |

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 KoskyChildren and Young Person’s FacilitatorFoyle Hospice, 61 Culmore Road Derry/Londonderry, BT48 8JETelephone: (028) 7135 1010 |
| **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: |