Healing Hearts
Children & Young Person's
Bereavement Support Service (4-16 yrs)

REFERRAL FORM FOR PRE/POST BEREAVEMENT SUPPORT

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: 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 ☐ NO ☐
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? YES ☐ NO ☐	Was the person who died a patient at Foyle Hospice or known to the Home Care Team? YES ☐ NO ☐

RELIGION		
Religious Belief: *(please select one)	Roman Catholic ☐	Protestant ☐
	If other please give details:	
	Not applicable: ☐	

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RELEVANT DETAILS

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

Past mental health history

Any known risks

Reason for referral now

Family Background/Further Information

Please clearly mark 'PRIVATE & CONFIDENTIAL' And return to:	**Michelle Kosky** **Children & Young Person's Facilitator** **Foyle Hospice** **61 Culmore Road** **L'Derry, BT48 8JE** **Tel: (028) 71 351 010**

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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: