



FOR OFFICE USE ONLY	CASE NO:
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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 <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? 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? YES <input type="checkbox"/> NO <input type="checkbox"/>

RELIGION	
Religious Belief: *(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
 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: