CHILDRENS BEREAVEMENT SUPPORT SERVICES

REFERRAL FORM

Date of referral:	Written/Phone/ Email

Name of child:	Gender: male/ female	
Address:		
Date of birth:	Ethnic origin:	
Name(s) of parent/ carer:	Relationship to the child:	
Address:	Religion:	Language spoken:
Postcode:	Email address:	
Phone number:	Mobile number:	

Name of person referring:	
Agency and position:	
Address:	
Contact phone number:	

PRE BEREAVEMENT SUPPORT	POST BEREAVEMENT SUPPORT
Person who is ill:	Who died?
Diagnosis:	Cause of death:
Prognosis:	Date of death:

REASON FOR REFERRAL (Please give as much information as possible. Ie concerns about the child, behavioural changes):
Is the child aware of this referral? YES / NO
Other agencies involved if applicable (CAMHS, school nurse, social care):

Name of GP and Surgery:	Permission to contact GP YES / NO
School contact and address:	

Date received:	First session:
Date of 1st contact:	Last Session:
Date of assessment:	No of session: