|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Referral** |  | **Client ID** |  |

|  |
| --- |
| **Contact Details** |
| Name |  |
| Address |  |
| Postcode |  |
| Mobile Phone | Can a message be left? Yes/No |
| Home Landline | Can a message be left? Yes/No |
| E Mail Address |  |
| D.O.B. |  |
| G.P  |  |
| G.P. Address |  |

|  |
| --- |
| **Details regarding the bereavement** |
| Name of person who died |  |
| Relationship |  |
| When did they die? |  |
| Where did they die? e.g. hospital. Home, care home |  |
| Any other information that you feel is relevant to share? |  |
| How did you hear about this service? |  |

|  |
| --- |
| **Previous support connected with bereavement** |
| Have you had support from any other organisation at any time | Yes/No |
| If yes, which organisation did you receive support from? |  |
| When did you receive that support? |  |

**Please complete when arranging support for the Client**

|  |  |
| --- | --- |
| Date contact made with client to arrange support |  |
| Assigned to: Listening Ear Bereavement Support Counselling Group |
| If none of the above - where was client signposted to |  |