|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of Referral** |  | | **Client ID** |  | |
| Is this person aware of referral | | |  | | |
| If ‘No’ please state reason | | |  | | |
| **Referrer Details** | | | | | |
| Referrer Name | |  | | | |
| Referrer Organisation | |  | | | |
| Referrer Tel No | |  | | | |
| **Client Contact Details** | | | | | |
| Name |  | | | | |
| Address |  | | | | |
| Postcode |  | | | | |
| Mobile Phone |  | | | | Can a message be left? Yes/No |
| Home Landline |  | | | | Can a message be left? Yes/No |
| Email |  | | | | |
| 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? |  |
| Any other information that you feel is relevant to share? |  |
| How did you hear about this service? |  |

|  |  |
| --- | --- |
| **Previous support connected with bereavement** | |
| Has this person had support from any other organisation at any time | Yes/No |
| If yes, can you please state from whom the support was received and when? |  |

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

|  |  |
| --- | --- |
| Date Referrer notified that Referral has been received |  |
| 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 |  |