|  |  |  |  |
| --- | --- | --- | --- |
| **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 |  |