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**Broad Lane, Rochdale, OL16 4PZ**

**Tel: 01706 649920 Fax: 01706 644943 Email:** [nehgm.liaison@nhs.net](mailto:nehgm.liaison@nhs.net)

**BEREAVEMENT SERVICE REFERRAL FORM**

**\*We accept referrals for adults bereaved by the loss of a loved one with a diagnosed life-limiting illness. We accept self-referrals for those families whose loved one was known to the Hospice.  We also accept referrals from GPs in Heywood, Middleton and Rochdale.**

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| **Has the client consented to this referral? Yes □ No □**  **Please note this referral will only be processed if the client is aware and has given consent** |

**Client details:**

|  |  |
| --- | --- |
| Surname: | Date of Birth: |
| First name: | Title: |
| Address: | Gender: |
| Ethnicity: |
| Religion: |
| Postcode: | Language: |
|  | Does the client have a disability? Yes □ No □  Please describe: |
| Landline No:  **Consent to leave a message** **Yes □ No □** | Is the client housebound: Yes □ No □ |
| Mobile No:  **Consent to leave a message** **Yes □ No □** | Does the client live alone: Yes □ No □ |

**Next of Kin details:**

|  |  |
| --- | --- |
| Surname | Address: |
| First name: |
| Relationship to client: | Postcode: |
| Tel: |

**Referrer:**

|  |  |  |
| --- | --- | --- |
| GP □ | Self □ |  |

**GP Other services involved:**

|  |  |
| --- | --- |
| GP name:  Address:  Tel:  Fax: | Other (please specify)  Tel: |
| Other (please specify)  Tel: |
| Other (please specify) |

**Nature of Bereavement**

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| **\*We only accept referrals for adults bereaved by the loss of a loved one with a diagnosed life-limiting illness**  **Date of Loss: Relationship to the client:**  **Diagnosed life-limiting illness:**  **Circumstances of death. Please give as much detail as possible:**  **Bereavement is a normal process and does not usually require intervention. Why do you feel this would be helpful for this client?** |

**Mental Health**

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| **\*\*Please note: If this client has a diagnosed mental health illness, or has multiple issues in addition to bereavement; it is more appropriate they be referred to IAPT/Thinking Ahead or another specialist psychotherapy service.**  **Is the client under care of a psychiatrist: currently \*\*Yes □ No □ or previously Yes □ No □**  Name: Tel:  Address:  **Are mental health services involved? \*\* Yes □ No □**  (please give as much detail as possible along with contact details)  **Any other psychological history? Previous counselling? Yes □ No □**  (please give as much detail as possible) |

**Risk**

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| **Risk of self-harm? Yes □ No □**  (please give as much detail as possible)  **Risk to others? Yes □ No □** |

**Medication**

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| **Is patient/client prescribed medication for anxiety and/or depression?**  Please list medication, start date and dose: |

**Please complete ALL sections to avoid delays in processing this referral**

|  |  |
| --- | --- |
| **Person completing referral:**  Print Name:  Signature: | **Designation:**  Tel:  Date: |