

# CLIENT REFERRAL PRE-BEREAVEMENT

**Referral details -**

Date of Referral: ……………………………………..Is Client aware of referral? Yes/No (if ‘no’ please explain below)

Referred by: Self / BH Dept/ External (print name): ……………………………………………………….

Is client known to Mental Health Services? Yes/ No (if ‘yes’, please explain below)

# Client details -

Name:……………………………………………………………. Title:…………… M/F/Other…………………………………

Date Of Birth:…………………………………………………….Ethnicity:……………………………………………………………………..

Address:……………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………

Telephone Nos: a) home: ……………………………… b) mobile: ……………………………………….……….

Email address:…………………………………………………………………………………………………………………………..

Preferred contact instructions, e.g. ok to telephone and/or write…………………………………………………….

……………………………………………………………………………………………………………………………………………..

Any other important contacts:…………………………………………………………………………………………………………………….

Religion:……………………………………………… GP/Practice:……..…………………………………….

# About the patient -

Name ………………………………………………………. M / F/Other……….……………… Date of Birth………………………

Relationship to client ……………………………………………………………………………

Address (if different from Client) ………………………………………………………………………………………………….

Diagnosis……………………………………………… Community Team Nurse: …………………………………………….



**Brief history/Reason for referral**

**Any risk or safeguarding issues?**

**Service Required (**please tick requested service below)

Information Advice Guidance Counselling

Art Therapy

Spiritual Care

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