

# 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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