

**For Office Use Only**

Date received: Completed by: Entered by:

 Client Code: Scanned:

**Referral Form**

**6-Week Grief Support - Cardiff North & West GP Cluster**

**Please complete this form using your/the client’s details and note that if completing it on behalf of someone else, you must have their permission to do so.**

Mr/Mrs/Ms/Miss: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it ok to write to the client at this address? YES/NO Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it ok to leave a message at these numbers? Home: YES/NO Mobile: YES/NO

First language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Second language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religion: \_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disabilities/special requirements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health concerns: YES/NO/NOT SURE

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GP Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referee Details: Name & Job Title ………………………………………………………………………………………………………….
Contact Number / Email: …………………………………………………………………………………………………………………………

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Information:**

Relation to the deceased – Parent / Child / Sibling / Grandparent / Aunt / Uncle / Cousin / Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cause of Death

* Natural Causes
* Death by Suicide
* Long-term Illness
* Sudden or Unexpected Death
* Murder
* Accident
* Unknown/ Other

Date of Bereavement

* Less than 3 months
* Between 3 - 6 months
* 6 - 12months
* More than a Year

Further Information ***- Please provide some basic information on the bereavement and reason for referral***

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Are there any risks/dangers that we need to be aware of? ………………………………………………………………………………………………………………………………………………………………………

Would you prefer a male or female support worker? M/F

**Availability – For telephone**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** |
| **Morning** |  |  |  |  |  |
| **Afternoon** |  |  |  |  |  |

Data Protection

I understand that my information will be kept on a secure database until it is no longer required to assist me or required by law. I give permission for CCAWS to contact me via telephone email post

I understand there is a privacy policy I can see if I wish.

Signature:

SEND TO info@ccaws.org.uk