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

**Tel: 01706 649920 Fax: 01706 644943 Email:** nehgm.liaison@nhs.net

**BEREAVEMENT SERVICE REFERRAL FORM**

**\*We only accept referrals for adults bereaved by the loss of a loved one *with a diagnosed life-limiting illness* from GPs in Heywood, Middleton and Rochdale.**

**Clients must be more than 3 months post bereavement and their bereavement must be the main contributor to their distress and not one of many issues.**

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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: |

**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:** **Must be more than 3 months post bereavement 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**

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| **GP completing referral:**Print Name:Signature: | Tel:Date: |