Adult Pre and Post Bereavement Support

Professional’s Referral Form (V1)

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| ACCEPTANCE CRITERIA   |  | | --- | | * The individual is aged 18+ * The individual and/or a loved one is known to St John’s Hospice * The individual and/or a loved one has been diagnosed with a life-limiting condition or has suffered a bereavement within the past 5 years | |



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| Data protection and confidentiality  In order to access this service, some of the information you submit will be shared with the patient’s registered GP and may also be shared with other relevant services. The data provided will be stored on St John’s Hospice’s electronic health record system. This will be explained further during the initial patient contact. | | | | | | | | |
| *All fields are mandatory* | | | | | | | | |
| **PERSONAL DETAILS** | | | | | | | | |
| **Surname:** | | **First Name:** | | | | **NHS No:** *(state if unknown)* | | **Date of birth:** |
|  | |  | | | |  | |  |
| **Address & Postcode:** | | | | | | **Telephone:** *(Home/Mobile)* | | **Email:** *(state if unknown)* |
|  | | | | | |  | |  |
| **Main Language:** | | | **Interpreter Required:** | | | **Registered GP:** *(Name & address of practice)* | | |
|  | | | Yes  No | | |  | | |
| **Gender:** | | **Ethnic Origin:** | | | | **Religion:** | | **Disability:** |
| Male  Female  Trans  Non-Binary  Other (please state): | | White British  White Other  Black/Black British  Asian/Asian British  Chinese  Mixed  Other (please state): | | | | Christian  Hindu  Jewish  Muslim  Sikh  Other (please state): | | Physical Disability  Learning Disability  Visual Impairment  Hearing Impairment  Autism Spectrum Condition (ASC)  Speech & Language  Other (please state): |
| **Accessibility Requirements** | | | | | | | | |
|  | | | | | | | | |
| **Relevant Medical History:** | | | | | | | | |
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| **REFERRAL DETAILS** | | | | | | | | |
| **What involvement has the individual had with St John’s Hospice?** | | | | | | | | |
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| **Presenting issues/difficulties:** | | | | | | | **What are you/the individual hoping to gain from this referral:** | |
|  | | | | | | |  | |
| **Are any other professionals involved in the patient’s care?** | | | | | | | | |
| Yes  No | *If yes, please detail:* | | | | | | | |
| **RISK SUMMARY** | | | | | | | | |
| **Risk to self:**  *(e.g., self-harm, suicidality,*  *substance misuse)* | | | | | Yes  No | *If yes, please detail:* | | |
| **Risk to others:** | | | | | Yes  No | *If yes, please detail:* | | |
| **Risk from others:** | | | | | Yes  No | *If yes, please detail:* | | |
| **Other risks:** *(if applicable)* | | | | |  | | | |
| **REFERRER DETAILS** | | | | | | | | |
| **Has the individual consented to this referral?** | | | | | | | | Yes  No |
| **Referrer Name:** | | | |  | | | **Email:** |  |
| **Role and Organisation:** | | | |  | | | **Telephone:** |  |
| **Address:** | | | | | | | **Signature:** | **Date:** |
|  | | | | | | |  |  |