Adult Pre and Post Bereavement Support

Self-Referral Form (V1)

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| ACCEPTANCE CRITERIA   |  | | --- | | * You are aged 18+ * You or a loved one are known to St John’s Hospice * You or a loved one have been diagnosed with a life-limiting condition; OR * You have 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 your 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 our initial telephone contact. | | | | | | | |
| *All fields are mandatory* | | | | | | | |
| **PERSONAL DETAILS** | | | | | | | |
| **Surname:** | | | **First Name:** | | **NHS No:** *(state if unknown)* | | **Date of birth:** |
|  | | |  | |  | |  |
| **Address & Postcode:** | | | | | **Telephone:** *(Home/Mobile)* | | **Email:** |
|  | | | | |  | |  |
| **Main Language:** | | | | **Interpreter Required:** | **Registered GP:** *(Name & address of practice)* | | |
|  | | | | Yes  No |  | | |
| **Gender:** | | | **Ethnic Origin:** | | **Religion:** | | **Disability:** |
| Male  Female  Trans  Non-Binary  Prefer not to say  Other (please state): | | | White British  White Other  Black/Black British  Asian/Asian British  Chinese  Mixed  Prefer not to say  Other (please state): | | Christian  Hindu  Jewish  Muslim  Sikh  Prefer not to say  Other (please state): | | Physical Disability  Learning Disability  Visual Impairment  Hearing Impairment  Autism Spectrum Condition (ASC)  Speech & Language  Prefer not to say  Other (please state): |
| **REFERRAL DETAILS** | | | | | | | |
| **Please explain your current difficulties:** | | | | | | | |
|  | | | | | | | |
| **What are you hoping to gain from this referral?** | | | | | | | |
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| **Please tick if you suffer from the following:** | | | | | | | |
| A mental health condition, such as depression or anxiety disorder  Difficulties with drug or alcohol use  Self-harm or thoughts of suicide  Risk from others, such as domestic violence or financial abuse  *Any additional detail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | |
| **Is anyone else involved in your care or support?** *(E.g., professional carers, family members or other organisations)* | | | | | | | |
| Yes  No | | *If yes, please detail:* | | | | | |
| **Are you currently receiving formal counselling with another service?** | | | | | | | |
| Yes  No | *If yes, please detail:* | | | | | | |
| **Signed:** | | | | | | **Date:** | |
|  | | | | | |  | |