Lakelands Hospice Bereavement Service

Referral Form

Please note that we require the client to be in agreement to this referral

Client Details:

Name: .....D.O.B: .....

Address: .....

.....Postcode: .....

Tel. No: Home: .....Mobile: .....

Work: .....

Do they have an answering machine? Yes/ No (Circle)

Outline the reason for referral (Please include nature and date of loss)

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Significant Medical Conditions: .....

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Cancer related referral Yes/ No ***Hospice Related Bereavement Yes/ No***

G.P Name: ..... Tel: .....

Address: .....

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Referral Source: *Date: .....*

Name of individual making the referral: .....

Address: .....

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.....Postcode: .....

Tel: Work: .....Mobile: .....

Please fax or post referral to Bereavement Service, Lakelands Day Care Hospice, Butland Road, Corby Northants. NN18 8LX – Tel: 01536 747755 Fax: 01536 747788

Referral Criteria

Lakelands Hospice Bereavement Service is run by a team of dedicated trained volunteers. You may refer directly to us, using the form overleaf. Please be kind enough to read the referrals criteria below and provide us with the details we require.

- ✓ Clients must live in Corby or the surrounding area
- ✓ Clients may be carers, relatives who are bereaved
- ✓ Clients must be over 18 years of age
- ✓ Clients must be in agreement for a referral to be made

Exclusion

The service is unable to accept referrals for clients with complex long-term mental health needs.

Notes on completion

- ✓ Wherever possible the initial contact will be by telephone so please provide an **up-to-date telephone number** for the client.
- ✓ The date of birth is essential information. **Please do not leave blank.**
- ✓ The nature and date of bereavement helps us to prepare for initial contact with the clients.

Please inform the client that you are making the referral and that initially we will contact them by phone.

Thank you