



Lakelands Hospice Bereavement Service Referral Form

Please note that the client must be in agreement to this referral (if not self referring)

Client Name----- D.O.B-----

Address-----

-----Postcode:-----

Telephone no : Home----- Mobile-----

Email:-----

Preferred method of contact :-----

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

Any significant medical conditions or disability -----

Is this a cancer related referral ? YES/NO

A Hospice related bereavement ? YES/NO

GP Name ----- Tel :-----

Practice Address-----



Referral Source: Please circle SELF HEALTH PROFESSIONAL OTHER
(please provide details if you are not the client)

Name of Individual making referral :-----

Address:-----

-----Postcode:-----

Tel Work :-----Mobile:-----

Email: -----

**On completion of the form please return via either post or fax to :-
Bereavement and Counselling Service,
Lakelands Day Care Hospice, Butland Road, Corby, Northants. NN18 8LX
Tel no : 01536 747755. Fax : 01536 747788**

**CAN WE HAVE AN EMAIL LINK for service????
AND THEN I CAN DO AN ELECTRONIC VERSION which can be forwarded solely
to that in box for assessment**