

Listening Ear Service

Adult Bereavement Support – Referral Form

ACCEPTANCE CRITERIA

- The individual is aged 18+
- The individual is a resident in Cornwall
- The individual has experienced a palliative bereavement within the past 3 years

Data Protection and confidentiality

In order to access this service, some of the information you submit may be shared with the patient's registered GP and may also be shared with other relevant services. The data provided will be stored on Cornwall Hospice Care's electronic system. This will be explained further during the initial patient contact.

All fields are mandatory

PERSONAL DETAILS

Title:	Full Name:	NHS No: <i>(state if unknown)</i>	Date of birth:
Likes to be called:	Telephone: <i>(Home/Mobile + preferred choice)</i>	Email: <i>(state if unknown)</i>	Client has consented to this referral:
Address & Postcode:		Registered GP: <i>(Name & address of practice)</i>	
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):

Please return this form to:

communityservices@cornwallhospice.org

Armed Forces Status:			
Regular serving ☐ Spouse/partner ☐	Reservist ☐ Spouse/partner ☐	Cadet Force ☐ Child ☐	Veteran ☐ Other (please state):
REFERRAL DETAILS			
Presenting issues/current difficulties:		What are you/the individual hoping to gain from this referral:	
Approx. date of death:			
Cause of death:			
Is anyone else involved in the client's care? (e.g., Professionals, family, or any other organisations?)			
Yes ☐ No ☐		If yes, please detail:	
WELBEING/RISK SUMMARY			
Risk to self: <i>(e.g., Severe mental health issues, self-harm, suicide ideation, substance misuse)</i>	Yes ☐ No ☐	If yes, please detail:	
Safeguarding concerns:	Yes ☐ No ☐	If yes, please detail:	
Other risks: (if applicable)			
REFERRER DETAILS			
Referrer Name:		Email:	
Role and Organisation:		Telephone:	
Where did you hear about this service:		Date of referral:	
COMMUNITY SERVICES USE ONLY:			
Outcomes:		Notes:	
Name:	Signature:		Date:

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