HOSPICE
LENNOX & ADDINGTON

Bereavement Support Referral Form

Referral Date _____

CLIENT INFORMATION

Name _____ Sex _____

Address _____

Primary Phone _____ Alternate Phone _____

Date of Birth _____ Health Card Number _____

I am interested in/I recommend (check all that apply):

- ❑ Individual Support (one-on-one)
- ❑ Group Support
- ❑ Resources

DETAILS OF LOSS

Name of Deceased _____

Date of Loss _____ Relation to Client _____

Cause of Death _____

REFERRAL INFORMATION

Referred by _____

Contact Number _____

Source

- ❑ Self
- ❑ Family
- ❑ Friend
- ❑ Agency. Please indicate:

_____

NOTES: