Bereavement Support Referral Form

Disclaimer: Hospice Lennox & Addington does not claim to offer a counselling service.

Referral Date ______________________________

CLIENT INFORMATION

Name ____ Sex ______________

Address ____

Primary Phone _______________________________ Alternate Phone __________________________________

Date of Birth ______________________________ Health Card Number _________________________________

Recommended Services/Services of Interest (check all that apply):

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

DETAILS OF LOSS

Name of Deceased ____

Date of Loss _________________________ Cause of death ____

Relationship: The deceased was ____ to the client.

REFERRAL INFORMATION

Referred by: ____

Phone: _______________________________________ Email: ____

- ❑ Self
- ❑ Family/Friend
- ❑ Home & Community Care
- ❑ Hospital
- ❑ Physician
- ❑ AMHS KFLA
- ❑ Hospice
- ❑ Other (specify): _______________________

CLIENT HISTORY

Is the client currently under the care of physician?

- ❑ YES Physician Name (if known): ____
- ❑ NO
- ❑ UNKNOWN

Does the client have a history of depression?

- ❑ YES If yes, are they on a prescribed medication? _____Y/N Details: ______________________
- ❑ NO
- ❑ UNKNOWN

Does the client have a history of anxiety?

- ❑ YES If yes, are they on a prescribed medication? _____Y/N Details: _______________________
- ❑ NO
- ❑ UNKNOWN

Other symptoms:

❑ CONFUSION	❑ SLEEPLESSNESS	❑ NUTRITION CONCERNS
❑ HEADACHES	❑ PHYSICAL PAIN	❑ SUICIDAL IDEATIONS

Other physical or mental health concerns?

- ❑ ____
- ❑ ____
- ❑ ____

Please include any additional information that may be helpful in supporting this client:

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