**Please note:**

**The information in this referral is requested to help with prompt decision making about eligibility for EACH bereavement services and the avoidance of any delay. This form can be completed by either a parent/carer or health or social care professional**

**Referred person / family details:**

|  |  |  |
| --- | --- | --- |
| Parent / Carer |  | Parent / Carer  |
| Name: |  | Same address? | Yes | [ ]  |  | Name: |  | Same address? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| Date of birth: |  |  | Date of birth: |  |
| NHS Number (if known) |  |  | NHS Number (if known) |  |
| Address if different: |  |  | Address if different: |  |
| Telephone: |  | Email: |  |  | Telephone: |  | Email: |  |
| Gender Identity | Male: |  | Female: |  |  | Gender Identity | Male: |  | Female: |  |
| Non-binary: |  | Other: |  | Non-binary: |  | Other: |
| Preferred Pronouns: |  |  | Preferred Pronouns: |  |
| Relationship to child: |  |  | Relationship to child: |  |
| Religion/Beliefs |  |  | Religion/Beliefs |  |
|  |  |  |
| Sibling/other 1 |  | Sibling/other 2  |
| Name: |  | Same address? | Yes | [ ]  |  | Name: |  | Same address? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| Date of birth: |  |  | Date of birth: |  |
| NHS Number (if known) |  |  | NHS Number (if known) |  |
| Address if different: |  |  | Address if different: |  |
| Telephone: |  | Email: |  |  | Telephone: |  | Email: |  |
| Gender Identity | Male: |  | Female: |  |  | Gender Identity | Male: |  | Female: |  |
| Non-binary: |  | Other: |  | Non-binary: |  | Other: |
| Preferred Pronouns: |  |  | Preferred Pronouns: |  |
| Religion/Beliefs: |  |  | Religion/Beliefs: |  |
| Relationship to child: |  |  | Relationship to child: |  |
|  |  |  |
| Sibling/other 3 |  | Sibling/other 4  |
| Name: |  | Same address? | Yes | [ ]  |  | Name: |  | Same address? | Yes | [ ]  |
| No | [ ]  |  | No | [ ]  |
| Date of birth: |  |  | Date of birth: |  |
| NHS Number (if known) |  |  | NHS Number (if known) |  |
| Address if different: |  |  | Address if different: |  |
| Telephone: |  | Email: |  |  | Telephone: |  | Email: |  |
| Gender Identity | Male: |  | Female: |  |  | Gender Identity | Male: |  | Female: |  |
| Non-binary: |  | Other: |  | Non-binary: |  | Other: |
| Preferred Pronouns: |  |  | Preferred Pronouns: |  |
| Religion/Beliefs: |  |  | Religion/Beliefs: |  |
| Relationship to child: |  |  | Relationship to child: |  |

|  |
| --- |
| Please confirm that the referred person (or those with parental responsibility) have consented to the referral? Yes [ ]  If this referral includes a child or young person who has capacity, please confirm that the young person has consented to the referral? *(if applicable)* Yes [ ]  No [ ]  N/A [ ]  Does the CYP / family agree to share their electronic care record Yes [ ]  No [ ]  |

**Deceased Child’s details:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Surname: |  | Forename(s): |  | Known as: |  |
| Date of birth: |  | Date of Death |  | NHS number: |  |
| Address: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Gender | Male: | [ ]  | Gender Identity | Male: | [ ]  |
| Female: | [ ]  | Female: | [ ]  |
| Transgender: | [ ]  | Non-binary: | [ ]  |
| Other: |  | Other: |  |
| Religion/ beliefs: |  | Preferred Pronouns: |  |

**Diagnosis:**

|  |  |
| --- | --- |
| Bereavement care can be provided where the cause of a baby, child or young person’s death would meet EACH eligibility. Please can you tell us what was the child / young person’s diagnosis/diagnoses and cause of death? |  |

|  |  |
| --- | --- |
| Who or what prompted you to make this referral to EACH?  |  |

**Please let us know if there is any other professional services providing bereavement support:**

| Name and Title: | Address: | Telephone number: | Email: | Type and frequency of support and service provided: |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are there any safeguarding concerns with the referred child and / or other members of the household? | Yes | [ ]  |  | If yes please give brief outline |  |
| No | [ ]  |

**Please let us know of any other additional information that may be relevant such as the current family circumstances:**

|  |
| --- |
|  |

**General Practitioner details:**

|  |  |  |  |
| --- | --- | --- | --- |
| GP Name: |  | Telephone: |  |
| Address: |  | Postcode: |  |
| Clinical Commissioning Group (CCG): |  | Email: |  |

**If completed by a referrer**

*By completing this referral form you are confirming that the family has agreed to the referral.*

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Job title:(if relevant) |  |
| Role: |  | Organisation: |  |
| Telephone numbers: |  | Email: |  |
| Signature: |  | Date: |  |

**Please return this completed form to** each.referrals@nhs.net