Please refer to the Devon Formulary and Referral websites for helpful primary care information for management of referrals and up to date referral criteria.

<http://southwest.devonformularyguidance.nhs.uk/>

The Bereavement Counselling Service is not an acute service so is not suitable for those who are in ‘normal’ grieving (intense sadness may be present but this is a normal grief response).

|  |  |
| --- | --- |
| **PLEASE X REASON FOR REFERRAL (ONE OR BOTH MUST APPLY)** | |
| **Traumatic loss i.e., murder, suicide, sudden or untimely death** |  |
| **Complex grief is evident. Complex grief takes many months to appear, we would not normally see this in someone who has been bereaved less than 6 months. Where necessary we would provide earlier intervention.** |  |

**Please complete in print (We do not accept hand written forms):**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient Surname: | |  | | | Patient Title: | |  | | Date of Birth: | |  | |
| Forename(s): | |  | | | |  | |  | Gender: | |  | |
| Address (& postcode): | | | | | | NHS Number: | | | Ethnicity: | | | |
| Preferred Tel No: | | | **Leave Message:** | | | | | | | | | |
| Tel No (Mobile): | | |  | | | | Tel No (Home): | | |  | | |
| Patient’s email: | | |  | | | | | | | | | |
|  | | |  | | | | | | | | | |
| **Referrers Details** | | | | | | | | | | |
| **Job Title (Must be GP or Mental Health Practitioner)** | | |  | | | | | | | |
| **Name** | | |  | | | | | | | |
| **Address:** | | |  | | | | | | | |
| **Contact number:** | | |  | | | | | | | |
| **Email:** | | |  | | | | | | | |

**Primary Reason for Referral:**

|  |  |
| --- | --- |
| **Information about the person who has died:** | |
| Person who died? |  |
| Patient’s relationship to bereaved person? |  |
| How did they die? |  |
| Where did they die? |  |
| Date of death? |  |

|  |
| --- |
| **Signs of trauma and/or complex grief** |
|  |
| Any other information: |
|  |

**Please include a list of current relevant medication and any other useful information.**

|  |
| --- |
| **Medication** |
|  |

***Are there any referrals to any other services pending?***

***Are there any potential lone working concerns i.e. hazards/safeguarding issues Yes No***

**Signature of referrer…………………………………….. Date………………………………………..**

**Please e-mail to** [**bcs.referrals@nhs.net**](mailto:bcs.referrals@nhs.net)