**Ormiston Families Stars Children’s Bereavement Support Service Referral Form**

The information below is needed to enable Ormiston Families Stars to support a child/young person safely and effectively. It will be held securely following receipt of this referral form. The child/young person’s parent/carer or young person aged 16 or over will be required to sign a form prior to or at assessment to state they are in agreement with this storage of information. If there are any related concerns in the meantime, please contact STARS on 01223 292276 or at info@talktostars.org.uk

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| --- | --- |
| 1. Date of referral |  |
| 2. Name of child/young person |  |
| 3. Date of birth |  |
| 4. Gender  |  |
| 5. Child/young person address |  |
| 6. School/college attending name and address |  |
| 7. Name of parent/carer  |  |
| 8. Parent/carer address if different from child/young person  |  |
| 9. Parent/carer phone number |  |
| 10. Parent/carer e-mail address |  |
| 11. GP name and surgery |  |
| 12. Is parent/carer aware of this referral? |  |
| 13. Referrer name (if not parent/carer) |  |
| 14. Referrer role in relation to child/young person |  |
| 15. Referrer phone number |  |
| 16. Referrer e-mail address |  |
| **If pre-bereavement support is required, please answer questions 17 - 20 and then go to question 25. If post-bereavement support is required, please go directly to question 21 and then continue to complete the form.**  |
| **Pre-Bereavement Support** |  |
| 17. Person who is ill |  |
| 18. Relationship to child/young person |  |
| 19. Diagnosis |  |
| 20. Prognosis |  |
| **Post-Bereavement Support**  |  |
| 21. Person who died |  |
| 22. Relationship to child/young person |  |
| 23. Date of death |  |
| 24. Nature of death |  |

|  |  |
| --- | --- |
| 25. Ethnicity |  |
| 26. Other services involved |  |
| 27. Past mental health history |  |
| 28. Any known risks |  |
| 29. Reason for referral now and any further information |  |

For office use only:

Case no: Project: