**Children & Adolescent Bereavement Referral Form**

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| **Name of child/young person being referred:** | **D.O.B:**  | **Age:** |
| **Ethnicity:** | **Gender:** | **Language:** | **Religion:** |

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| **Name of primary/secondary school child attends:**  | 1. **GP Name and Address:**
2. **Does the child/Young person have a disability?** *This could be learning or physical*
3. **Is the child/YP Neurodiverse? E.g***. ASD, ADHD,*
4. **Any other medical conditions?**:
 |
| **Family information****Main carer(s) and relationship to child**: **Address:** **Daytime contact number:** **Evening contact number:****Email**:**Siblings****Name:** **Age: D/O/B:****Name:** **Age: D/O/B****Name:** **Age:** D/O/B |
| **For some children/YP a parent/carer will be required to attend the initial sessions to ensure the child feels safe and familiar with the space and therapist:** **Parent/carer/s attending sessions:** **Date of Birth:****GP contact:** |

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| **Reason for referral:** |
| **Is the young person aware of the referral being made?** |

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| **Name of deceased:** | **Relationship to child/young person:** | **Age:** |
| **Cause of death: Date:** |

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| **Family Tree (useful if you can provide):**  |
| **Children’s support network (Including professional services – school, CAMHS):** |

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| **Any other significant losses/events/risks:** *(e.g. moved home, school, issues around birth, early development, bereavements, self-harm, suicidal thoughts or feelings)*  |
| **Any further relevant information, which you feel, will be helpful?** **Please include family spiritual or cultural beliefs and traditions** |
| **Where did you hear about the service?** |

**permission for child/youNG Person to attend Bereavement suppport therapy**

**I/we:**

**Relationship to the child (Parent/guardian/carer):**

**Give consent for** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **To receive bereavement therapy support. Confidentiality and assessment will be discussed, clarified and agreed prior to the sessions starting.**

***Signature of parent/guardian/carer:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Professional making referral:**

**Name:**

**Organisation:**

**Family permission to make referral: YES / NO**