**

**Wakefield District Bereavement Service Referral Form**

**The Wakefield District Bereavement Service CAN support:**

* **Individuals who are experiencing challenges following the death of a loved one.**
* **Those aged 18+**
* **Individuals who will benefit from time-limited support.**

**The Wakefield District Bereavement Service CANNOT support:**

* **Individuals who are in crisis**
* **Children under the age of 18**

**Note:** By completing and returning this form you are consenting to us storing your information on our secure system.

**Please send completed form to:** [**bereavement@ageukwd.org.uk**](mailto:bereavement@ageukwd.org.uk)

**SECTION 1 - CLIENT DETAILS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Mr Mrs Miss Ms Other (please state)**  **Client Name:**  **Prefers to be known as:** | | | **Date of Birth:** | |
| **Client Telephone No:** | |
| **Address:**  **Postcode:** | | | **Registered GP Practice:** | |
| **Has the client consented to referral?** | **Yes** | **No** | |  |
|  | | | | |
| **Please state any communication needs:**  *(e.g.. hearing/speech/sight/cognitive/language)* | | | | |
| **Please provide a brief description of the reason you are referring yourself/this person:**  *This could include:*   * Any personal circumstances you would like us to be aware of * A short explanation of the bereavement * Date of death | | | | |
| **Are there any other services supporting you/this person?** *(Please provide service name, nature of the support, if this has an end date or is ongoing and any key professional contact details)* | | | | |
| **Do you/this person consent to us sharing information with**  **these services to allow us to best support them? Yes No** | | | | |
| **What support would you/the person like from Wakefield District Bereavement Service?**  *Please include clients wishes where possible. If you are unsure at this time, please leave this section blank and one of our team will be able to discuss this with you.* | | | | |

|  |  |
| --- | --- |
| **SECTION 2 - REFERRER’S DETAILS (if different to the above)** | |
| **Referrer’s name:** |  |
| **Referrer’s address/organisation:** |  |
| **Referrer’s Tel no/email address:** |  |
| **Relationship to referred:** |  |

**For Professional Referrals Only (Self referrals may skip this section)**

**SECTION 3 - RISK ASSESSMENT**

To ensure we can support the individual you have referred, in the safest way, we ask that you carefully consider the following questions and provide as much detail as possible.

Where risks are identified, please provide details of how these are currently managed.

|  |
| --- |
| **Does the individual pose any current or historical risk to themselves?**  *(e.g. self-harm, suicidal thoughts, self-neglect, etc)* |
| **Is the individual at risk of harm from others?** *(e.g. abuse, neglect, vulnerability)* |
| **Does the individual pose any current or historical risk to others?**  *(e.g. family members, staff, members of the public)* |
| **Does the individual have any allergies or medical conditions that we need to be aware of?** |

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***This section is intended for AgeUKWD use only:***

|  |  |
| --- | --- |
| **Referral received by: *(name)*** |  |
| **Referred to: *(staff/volunteer name)*** |  |

**Age UK Wakefield District** **t:** 01977 552114

7 Bank Street **e:** admin@ageukwd.org.uk

Castleford **www.ageukwd.org.uk**

WF10 1JD

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