**

**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**
* **Support children under the age of 18**
* **Support in the instance of death by suicide (Leeds Mind offer a dedicated service for this -** [**Suicide Bereavement Services - Leeds and West Yorkshire - Leeds Mind**](https://www.leedsmind.org.uk/suicide-bereavement-services-west-yorkshire/)**)**
* **Offer counselling unless you are 4-months post bereavement (due to the natural grieving processes that occur following a loss)**

**Use of Personal Data:**

The personal information given on this form will be used to provide services as discussed. It will be stored and processed securely. Our privacy policy explains how we use personal data. This is available on the Age UK Wakefield District website at <https://www.ageuk.org.uk/wakefielddistrict/privacy-policy/>

To deliver the Wakefield District Bereavement Service we are working in partnership with Turning Point Talking Therapies. If you consent to this referral, we may share your referral information with them and they could be in contact with you to offer support if they are best placed to do so.

**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:** | **Client Email Address:** | | | |
| **Client GP Practice:** | | | |
| **Does the person needing support consent to this 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 should 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)* | | | | |
| **Does the person needing support consent to us sharing information with the services named above to allow us to best support them?** | | **Yes  No** | | |
| **What support would the person needing support 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.* | | | | |

|  |  |
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| **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:** |  |

**SECTION 3 - RISK ASSESSMENT (optional for self-referrals)**

To ensure we can support the person 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.

**Note for professionals:** Referrals will not be accepted if this section is not completed.

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| **Does the person needing support pose any current or historical risk to themselves?**  *(e.g. self-harm, suicidal thoughts, self-neglect, etc)* |
| **Is the person needing support at risk of harm from others?** *(e.g. abuse, neglect, vulnerability)* |
| **Does the person needing support pose any current or historical risk to others?**  *(e.g. family members, staff, members of the public)* |
| **Does the person needing support 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**

7 Bank Street

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**www.ageukwd.org.uk**

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