Cornwall Hospice Care
• Mount Edgcumbe Hospice • St Julia's Hospice •
Caring for our community

# Listening Ear Service

## Adult Bereavement Support Referral Form

**ACCEPTANCE CRITERIA**

- The individual is aged 18+
- The individual is a resident in Cornwall
- The individual has experienced a bereavement within the past 3 years

**Data protection and confidentiality**

In order to access this service, some of the information you submit may be shared with the patient's registered GP and may also be shared with other relevant services. The data provided will be stored on Cornwall Hospice Care's electronic system. This will be explained further during the initial patient contact.

*All fields are mandatory*

**PERSONAL DETAILS**

| **Title:** | **Full Name:** | **NHS No:** *(state if unknown)* | **Date of birth:** |
|---|---|---|---|
| | | | |

| **Likes to be called:** | **Telephone:** *(Home/Mobile + preferred choice)* | **Email:** *(state if unknown)* | **Client has consented to this referral:** |
|---|---|---|---|
| | | | |

| **Address & Postcode:** | **Registered GP:** *(Name & address of practice)* |
|---|---|
| | |

| **Gender:** | **Ethnic Origin:** | **Religion:** | **Disability:** |
|---|---|---|---|
| Male ☐<br>Female ☐<br>Trans ☐<br>Non-Binary ☐<br>Other (please state): | White British ☐<br>White Other ☐<br>Black/Black British ☐<br>Asian/Asian British ☐<br>Chinese ☐<br>Mixed ☐<br>Other (please state): | Christian ☐<br>Hindu ☐<br>Jewish ☐<br>Muslim ☐<br>Sikh ☐<br>Other (please state): | Physical Disability ☐<br>Learning Disability ☐<br>Visual Impairment ☐<br>Hearing Impairment ☐<br>Autism Spectrum Condition (ASC) ☐<br>Speech & Language ☐<br>Other (please state): |

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| **Armed Forces Status:** | | | |
|---|---|---|---|
| Regular serving ☐<br>Reservist ☐<br>Cadet Force ☐<br>Veteran ☐<br>Spouse/partner ☐<br>Child ☐<br>Other (please state): | | | |

| **Relevant Medical History/Health Issues:** |
|---|
| |

## REFERRAL DETAILS

| **Presenting issues/current difficulties including date of bereavement:** | **What are you/the individual hoping to gain from this referral:** |
|---|---|
| | |

| **Is anyone else involved in the client's care?** *(e.g., Professionals, family, or any other organisations?)* | |
|---|---|
| Yes ☐ No ☐ | *If yes, please detail:* |

## WELBEING/RISK SUMMARY

| | | |
|---|---|---|
| **Risk to self:** *(e.g., Severe mental health issues, self-harm, suicide ideation, substance misuse)* | Yes ☐ No ☐ | *If yes, please detail:* |
| **Safeguarding concerns:** | Yes ☐ No ☐ | *If yes, please detail:* |
| **Other risks:** *(if applicable)* | | |

## REFERRER DETAILS

| | | | |
|---|---|---|---|
| **Referrer Name:** | | **Email:** | |
| **Role and Organisation:** | | **Telephone:** | |

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| Where did you hear about this service: | | Date of referral: |
|---|---|---|
| | | |
| **COMMUNITY SERVICES USE ONLY:** | | |
| **Outcomes:** | | **Notes:** |
| | | |
| **Name:** | **Signature:** | **Date:** |

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