



Scottish Charity Number SC006704
www.strathcarronhospice.org

Seasons Group Referral Form



Name of Young Person: _____

Address _____

(inc Post Code) _____

Telephone No.(s) _____

Date of Birth: DD/MM/YYYY | Age: | School Year: _____

Does the young person know about and agree to this referral? Yes No

Does the young person have any allergies? (medications, food etc) Yes No

If yes, please explain _____

Name of Parent/Carer _____

Address _____

(if different to young persons) _____

(inc. Post Code) _____

Telephone No.(s) _____

Does the parent/carer know about and agree to this referral? Yes No

Is the parent/carer willing to attend the adult group? Yes No

If no, who will be attending? _____

Name & Address of Person making the referral: _____

(inc Post Code) _____

Telephone No.'s _____

Relationship to young person _____

Name of Person who Died:-	Relationship to young person:-
Cause of Death:-	Age at Death:-
	Date of Death:-

Length of Time Since Death:- 0-2months 2-6months 6-12months 12-18months 18-24months +2years

Why are you referring this young person? Please include as much information as possible including any emotional/psychological needs, behavioural problems and social concerns (Please attach another sheet if necessary.)

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What does the young person know of the details of the death? (Do they know how, when, etc & did they attend the funeral?)

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How did you hear about this 'Seasons' Group? Hospice Staff Internet School Social Work CAMHS

Leaflet/poster ILC CHCP other please specify.....

Referrers Signature..... Print Name..... Date.....

Referrals can be sent by post, faxed or emailed to:

Bereavement Support, Strathcarron Hospice, Randolph Hill, Denny. FK6 5HJ

Tel: 01324 826222 Fax: 01324 826119 email: seasons@strathcarronhospice.org

For Office Use Only

Date Referred..... Date of First Contact..... Acknowledgement Letter Sent.....

Group Assigned HCAS No. Discharge Letter Sent.....

Comments.....

..... Transport? Yes No