REFERRAL TO

Arohanui Hospice Bereavement Service

Please use this form to refer patients or family members who require bereavement support

Please Fax To: (06) 356 6631

PO Box 5349, Palmerston North 4414

BEREAVED PERSONS DETAILS IF KNOWN (APPLY BRADMA OR COMPLETE DETAILS)

Surname	First names
Address:	
Email	Telephone No
Relationship to the deceased:	DOB
Ethnicity	Patient NHI:

Usual accommodation: (select one)

- ☐ Private residence (incl. retirement village)
- ☐ Residential aged care, low level care (level 2 rest home)
- ☐ Residential aged care, high level care (hospital level)
- ☐ Public Hospital
- ☐ Other (eg corrections facility) _____

Level of current support: (select one)

- ☐ Lives alone with no care/support provided
- ☐ Lives with others with no care/support provided
- ☐ Lives alone with external professional support
- ☐ Lives with others who provide care/support
- ☐ Lives with others with external professional support
- ☐ Not stated/inadequately described/not applicable

DECEASED PATIENT DETAILS IF KNOWN (apply Bradma or complete details)

Surname	First names	
Address		
Diagnosis	DOB	DOD
Reason for Referral:		

(Reason for Referral continued)

Risk Assessment

- ☐ Traumatic witness
- ☐ Lack of social support
- ☐ Death of a child
- ☐ Pre-existing factors (e.g. unresolved grief, alcohol, or drug dependency)
- ☐ Centrality (person is the center of their world)
- ☐ Concurrent crises
- ☐ Perceived preventability (i.e. believed by the relative/friend to be preventable).

Level of current support: (select one)

- ☐ Overly prolonged dying
- ☐ Ambivalence about the relationship
- ☐ Disrupted grief process (i.e. people who can't be there or are unable to be part of the normal grieving process).
- ☐ Strictly defined role within the relationship
- ☐ Other significant deaths
- ☐ Family Discord
- ☐ Other _____

Name of Referring Health Professional

GP Practice or Hospital Clinic/Specialty

Contact phone number

Signature:

Date: ____/____/____