

REFERRAL TO AROHANUI HOSPICE BEREAVEMENT SERVICE

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

Please email to: Referrals@arohanuihospice.org.nz

Bereaved persons:		
Surname:	First Names:	
Address:		
Email:	Telephone No:	
Relationship to the deceased:	DOB:	
Ethnicity:	Patient NHI:	
Has this person consented to the referral and the forwarding of their information? Yes / No (select one)		
If the person being referred is under 16 years of age, has the parent or guardian consented to the referral and		
forwarding of information? Yes / No (select one)		
Usual accommodation: (select one)	Level of current support: (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 	☐ 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	
Other (e.g. correctional facility)		
Deceased Patient Details If Known (apply Bradma or complete details):		
Surname:	First Names:	
Address:		
Diagnosis:	DOB:DOD:	
Reason for Referral		
Please Turn Over		

(Reason for Referral continued)		
Diela Accessorate		
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 centre of their world)	Concurrent crises	
Perceived preventability (i.e. believed by the relative/friend to be preventable)	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	Family Discord	
☐ Other significant deaths	☐ Other	
Name of Referring Health Pofessional:		
GP Practice or Hospital Clinic/Specialty:	Contact phone number:	
Signature:	Date:	