



**CHILDREN and YOUNG PERSON
BEREAVEMENT SUPPORT WORKER
Referral Form**

	Date:
Parent/Guardian Name:	
Address:	
Post Code:	
Telephone:	
Mobile:	
Email:	

Child's / Children's Name/s	Gender	Date of Birth	School	Year Group

Ethnicity Details:

- White British White Irish Any Other White Caribbean African
Any Other Black Indian Pakistani Bangladeshi White/Black Caribbean
White/Black African White/Asian Chinese Any Other Mixed Traveller

DETAILS OF BEREAVEMENT

Name of deceased?	
Date of death?	
Age at death?	
Relationship to child?	
Any other details/comments you wish to add about the death?	

If you have suffered more than one bereavement, please complete the following:

Name of deceased?	
Date of death?	
Age at death?	
Relationship to child?	
Any other details/comments you wish to add about the death?	

What is the reason for your seeking bereavement support now and what would you like to achieve?	
Does the named child/children have a learning or other disability? Please provide details.	
Is there any information you consider important for us to know about the named child/children eg sleeping, eating, behavioral difficulties since death? Please provide details.	
Where would you prefer the child/children to be seen? Sessions take place weekly at the same time and day.	<input type="radio"/> At School during school hours <input type="radio"/> After School at our premises in Catherine Street, St Albans

