POST BEREAVEMENT REFERRAL DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PLEASE READ OUR REFERRAL GUIDANCE PRIOR TO COMPLETING THIS FORM.** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1. CHILD/YOUNG PERSON DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of Child** | | | | | | | | **DOB** | | **Age:** | | | | | | | **M/F** | | **School/Setting & Year** | | | | | **Ethnicity \*** | |
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| *\* Please use options outlined in Section 7 of this form.* | | | | | | | | | | | | | | | | | | | | | | | | | |
| **2. PARENT/GUARDIAN DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name(s):** | | | | | | | | | **Relationship(s) to child:** | | | | | | | | | | | | | | | | |
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| **Parents are/were:** | | | | **Living together / Separated / Divorced** | | | | | | | | | | | | | | | | | | | | | |
| **Address:** | | | |  | | | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | | | **Postcode:** | | | |  | | | |
| **Home Phone:** | |  | | | | | | | | | | **Mobile :** | | | | | |  | | | | | | | |
| **Email:** | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Religion or belief (if any) please specify:** | | | | | | |  | | | | | | | | | | | | | | | | | | |
| **Family consent for referral:** | | **Yes / No** | | | **Family consent to share information with other relevant professionals including Social Care, Early Help Services, Education, CAMHS & GP:** | | | | | | | | | | | | | | | | | | | | **Yes / No** |
| **Name of person giving consent** | |  | | | | | | | | | | | | | | **Does this person have Parental responsibility?** | | | | | | | | | **Yes / No** |
| **3. BEREAVEMENT DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Person who died (Relationship to child)** | | | **Cause of death** | | | | | | | | | | | | | **Date of death** | | | | | | | **Was this person a main carer to child?** | | |
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| **4. OTHER PROFESSIONALS INVOLVED** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Safeguarding :** | | **Yes / No** | | | | | | | | **Child In Care:** | | | | | | | | | | | **Yes / No** | | | | |
| **Child in Need:** | | **Yes / No** | | | | | | | | **Child Protection Plan:** | | | | | | | | | | | **Yes / No** | | | | |
| **Known to CAMHS?:** | | **Yes / No** | | | | | | | |  | | | | | | | | | | | | | | | |
| **Is a CAF/TAC/Early Support in place for this child?** | | **Yes / No** | | | | | | | |  | | | | | | | | | | | | | | | |
| **If yes, please give lead professional’s details:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Would a home visit be OK ?** | | **Yes / No** | | | | **If yes, please specify any known risk factors e.g. people, pets, property and location** | | | | | | | | |  | | | | | | | | | | |
| **Details of any other professionals involved:** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | **Role** | | | | | | | | **Contact details inc email/tel no** | | | | | | | | | | | | | | | |
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| **Child/young person’s GP & Surgery:** | | | |  | | | | | | | | | | | | | | | | | | | | | |
| **5. REFERRAL DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please give details of any known history of self harm, suicidal thoughts, behavioural concerns and additional needs of the above child (ren) and their parents/carers:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Please explain why you are making this referral to Penhaligon’s Friends giving details of any specific incidents which have prompted your concern:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Please describe any behavioural changes in the child/ren since the bereavement:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Is bereavement currently the principal issue for this child/ren and family?** | | | | | | | | | | | | | | **Yes / No** | | | | | | | | | | | |
| **If no, please give details of other issues which may also be affecting the child/ren and the family:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **What support do you feel the child/ren/young person and family require around their bereavement?:** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **6. REFERRER DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | | |  | | | | | | | **Organisation:** | | | | | | | | |  | | | | | |
| **Contact number:** | | | |  | | | | | | | **Role:** | | | | | | | | |  | | | | | |
| **Address:** | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | **Postcode:** | | | | | | |  | | | | | |
| **Email:** |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **What is your involvement with the family, child or young person (please include how long you have known them and in what capacity, and what work you have already been doing to support them)?** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Thank you for taking the time to complete this referral form with as much detail as possible.  Please return the completed form by email to: [enquiries@penhaligonsfriends.org.uk](mailto:enquiries@penhaligonsfriends.org.uk) or by post to:  Penhaligon’s Friends, Trecarrel, Drump Road, Redruth, TR15 1LU | | | | | | | | | | | | | | | | | | | | | | | | | |

**7. CHILD/YOUNG PERSONS ETHNICITY**

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| --- | --- | --- | --- | --- | --- |
| ☐ | **White - British** | ☐ | **Mixed – Any other mixed background** | ☐ | **Black or Black British - Caribbean** |
| ☐ | **White - Irish** | ☐ | **Asian or Asian British - Indian** | ☐ | **Black or Black British - African** |
| ☐ | **White – Any Other White Cultural Background** | ☐ | **Asian or Asian British - Pakistani** | ☐ | **Black or Black British – Any other Black background** |
| ☐ | **Mixed – White and Black Caribbean** | ☐ | **Asian or Asian British - Bangladeshi** | ☐ | **Chinese** |
| ☐ | **Mixed – White and Black African** | ☐ | **Asian or Asian British – Any other Asian background** | ☐ | **Any other ethnic group** |
| ☐ | **Mixed – White and Asian** |  |  |  |  |