



Hospice Niagara Bereavement Support Program Referral Form

Last Name: _____ First Name: _____

Address: _____ City: _____

Postal Code: _____ Phone: _____

Email: _____

Date of Birth/Age: _____ Male/Female: _____

Others within family requesting support: Please provide name, age and contact information (if different).

Relevant Information Pertaining to Referral:

Name of Deceased: _____ Date of Death: _____

Relationship with the Deceased: Some Conflict Fairly Close Very Close

Cause of Death: _____

Individual's reaction to the death: _____

Please describe any additional information or comments that may be beneficial:

Permission given by individual for Hospice Niagara's Bereavement Advisor to contact them.

Referral from: _____ Organization: _____

Contact Information: _____

Signature: _____

Please mail or fax this referral to: Lynn Mytroen, Bereavement Advisor

Fax Number: 905-905-984-8242

Mail: Hospice Niagara, 403 Ontario Street, Unit 2, St. Catharines, Ontario L2N 1L5