

HOSPICE NIAGARA TEEN 2 TEEN REFERRAL FORM



Name: _____

Address: _____

Phone: _____ Email: _____

Age: _____ Grade: _____ Male/Female: _____

School: _____

School Contact: _____ Phone: _____

Parent/Guardian Contact Information

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Relevant Medical Information:

Health Card Number: _____

Relevant Medical History (e.g. seizures, ADD): _____

Allergies &/or Food restrictions (e.g. peanut, celiac disease): _____

Medications: _____

Activity Restrictions: _____

Relevant information regarding Death

Name of Deceased: _____ Date of Death: _____

Relationship (e.g.: parent, close or distant etc.): _____

Cause of Death: _____

Brief description of emotions, behaviour and coping skills:

Please note any high risk behaviour issues e.g. suicide, school suspension, fights, drug/alcohol use etc.

Parent/legal guardian is aware of the Teen 2 Teen: My Grief Story event.

Completed by: _____ Date: _____

Send form to the attention of: *Melissa Penner, Bereavement Advisor, Hospice Niagara*
Fax: 905-984-8242 Email: teen2teen@hospiceniagara
Address: 403 Ontario Street, St. Catharines, ON L2N 1L5

Signature: _____

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