HOSPICE NIAGARA
helping you live well

Bereavement Support Program Referral Form

Referral Date: _____

First Name: _____ Last Name: _____

Address: _____ City: _____

Postal Code: _____ Phone: _____

Email: _____

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

Name of Parent/Guardian (if child/teen): _____ Phone (if different): _____

Program Requested:

☐ **Grief Circle** (adult) Location: ☐ St. Catharines ☐ Welland ☐ Niagara Falls ☐ **Mindfulness Hike**

☐ **Grief Walk** Location: ☐ North St. Catharines ☐ Thorold (Central) ☐ Welland (South)

☐ **Family Support Group** (ages 6 – 13 & guardians) ☐ **Preteen Thrive** one day retreat (ages 11 – 13)

☐ **Teen Support Group** ☐ **Teen 2 Teen: My Grief Story** one day retreat (ages 14 – 18) ☐ **Bereavement** ☐ **Visiting Volunteer**

Relevant Medical information

Medications: _____ Activity Restrictions: _____

Allergies: _____ ☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Dairy Free ☐ Nut Free

Relevant Information Pertaining to Referral:

Name of Deceased: _____ Date of Death: _____

Deceased is the _____ (relationship) to the bereaved 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: _____

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