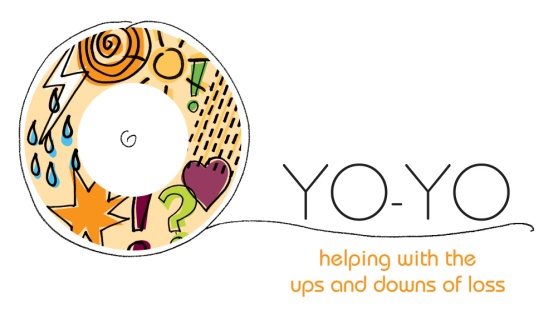
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**THE YO-YO PROJECT CHILDREN & YOUNG PERSONS**

**BEREAVEMENT COUNSELLING REFERRAL**

Please complete this form fully, providing as much information as you can. Referrals will be accepted into the service if they meet the Yo-Yo Project referral criteria.

**Family details**

|  |  |
| --- | --- |
| **Name of parent/carer:** | **Relationship to child/young person:** |
| **Address:**    **Post Code:** | **Telephone no.**  **Mobile no.**  **Email:** |

**Please list below the child/young person you are referring to the service**

(Separate forms must be completed for additional children/young people)

|  |  |  |  |
| --- | --- | --- | --- |
| **Child/Young Person’s Name:** | | **D.O.B:** | **Age:** |
| **Ethnicity:** | **Gender:** | **Language:** | **Religion:** |
| **School:** | | **GP Details:** | |
| **Disability/Medical conditions:** | | | |
| **Learning/Behavioural needs:** | | | |
| **Is there anyone else involved in their care:** | | | |

***REFERRALS ARE WELCOME ONLY FROM 6 WEEKS AFTER THE DATE OF DEATH***

**Please provide details about the deceased**

|  |  |  |
| --- | --- | --- |
| **Name of deceased:** | **Relationship to child/young person:** | **Age:** |
| **Circumstances/Cause of death:** | | **Date of death:** |

|  |
| --- |
| **Please describe the impact of the bereavement on the child/young person and highlight areas for concern** (continue on a separate sheet if necessary)**:** |
| **Any other significant events/risks:** (*e.g. issues around birth/infancy, childhood development, relevant family events, bereavements, losses, suicidal thoughts or feelings*) |
| **Family Tree (helpful): Example**  Twins  Kevin (18)  Mary (14) |

**Details of person referring**

|  |  |
| --- | --- |
| **Name:** | **Relationship to child/young person:** |
| **Is this information the same as on Page 1 Y  N**  *If No, please complete below* | |
| **Address:**    **Post Code:** …………………………………... | **Telephone no.**  **Mobile no.**  **Email:** |

**Consent**

(*All children/young people MUST consent to accessing the service before we meet them. We will not progress referrals without their consent/knowledge*)

|  |
| --- |
| **Is the child/young person aware of the referral? Y  N**  *If No, please give reasons:* |
| **Is the parent/carer aware of the referral: Y  N**  *If No, please give reasons:* |

|  |
| --- |
| **Signature:** |
| **Print name:** |
| **Date:** |

Please send this form or email to: **The Yo-Yo Project,** **Farleigh Hospice, North Court Road, Chelmsford, Essex CM1 7FH Tel. No. 01245 457416 Email:** [**yoyoproject@farleighhospice.org**](mailto:%20yoyoproject@farleighhospice.org)

The Yo-Yo Project referral criteria is available to view on the website – [www.farleighhospice.org/bereavement-support](http://www.farleighhospice.org/bereavement-support). Farleigh Hospice will retain information on this form in line with their protocol, policy & GDPR regulations. You are welcome to see these policies upon request & access information under GDPR guidelines.

The Yo-Yo Project is a part of Farleigh Hospice Services

Registered address: Farleigh Hospice, North Court Road, Chelmsford CM1 7FH Tel: 01245 457416

Email: [Bereavement@farleighhospice.org](mailto:Bereavement@farleighhospice.org) Web: [www.farleighhospice.org](http://www.farleighhospice.org)

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