



**NEAR NORTH PALLIATIVE CARE NETWORK**

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CLIENT #

**BEREAVEMENT CLIENT REFERRAL**

Date: \_\_\_\_\_  
 (MM/DD/YYYY)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ DOB: \_\_\_\_\_  
 (MM/DD/YYYY)

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Deceased: \_\_\_\_\_ Date of Death: \_\_\_\_\_

**Relationship to Deceased:**

- Wife  Husband
- Daughter  Son
- Sister  Brother
- Mother  Father
- Friend
- Other  \_\_\_\_\_

Age at Death: \_\_\_\_\_

**Nature of Death:**

- Unexpected  \_\_\_\_\_
- Illness/Long Term  \_\_\_\_\_
- Suicide  \_\_\_\_\_

<p><b>Was the deceased a client of NNPCN?</b>          YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p><b>What are you looking for?</b></p> <ul style="list-style-type: none"> <li>Telephone Support <input type="checkbox"/></li> <li>Information Session <input type="checkbox"/></li> <li>Individual Session <input type="checkbox"/></li> <li>Group Session <input type="checkbox"/></li> <li>Anticipatory Grief Support <input type="checkbox"/></li> <li>Other (specify): <input type="checkbox"/> _____</li> </ul> <p><b>Best time to contact you:</b>          Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/></p>	<p><b>Are you currently being seen by a health care professional/ attending a support group/walk-in?</b> YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Name/Title/Phone no. of your Health Care Professional(s) (area of specialization) and service(s) provided:</p> <p>Medical/Nursing: _____ <input type="checkbox"/></p> <p>Counseling Area: _____ <input type="checkbox"/></p> <p>AA: _____ <input type="checkbox"/></p> <p>Mental Health: _____ <input type="checkbox"/></p> <p>Drugs: _____ <input type="checkbox"/></p> <p>Other (specify): _____ <input type="checkbox"/></p>
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**How did you hear about our service?** Brochure  Family  Friend  Website  Other (specify) \_\_\_\_\_

**Follow-up needed:** YES  NO  **Specify:** Urgent  Regular  Complex  Other (specify) \_\_\_\_\_

**Additional Information on Reverse**

**GRAYED AREA FOR NNPCN INTERNAL USE ONLY, PLEASE DO NOT FILL.**

<b>Intake Date</b>	<b>Intake by</b>		
Telephone Support <input type="checkbox"/>	Discharge Date	Discharge by	
Information Session <input type="checkbox"/>	Discharge Date	Discharge by	
Individual Session <input type="checkbox"/>	Discharge Date	Discharge by	
Group Session <input type="checkbox"/>	Discharge Date	Discharge by	
<b>Re-contact</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Archive Date</b>	<b>Archived by</b>	

**Confidentiality.** The information contained in this communication is private and confidential, intended only for the named recipient(s). If received in error, please notify the sender by telephone immediately and keep the information in a secure manner until further direction is given by the sender. Do not copy the information or disclose it to any other person.

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