NEAR NORTH PALLIATIVE CARE NETWORK
2025 Main Street West, North Bay ON, P1B 2X6
Phone: 705-497-9239 1-800-287-9441 Fax: 705-497-1039
Sturgeon Falls: 705-753-3110 ext. 339
E-mail: office@nnpcn.com Website: www.nnpcn.com

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: ____________________________

Deceased was the ___ of the client:

Wife ☐ Husband ☐
Daughter ☐ Son ☐
Sister ☐ Brother ☐
Mother ☐ Father ☐
Friend ☐
Other ☐ ___________________________

Age at Death: ____________________________

Nature of Death:
Unexpected ☐ __________________________________
Illness/Long Term ☐ __________________________________
Suicide ☐ __________________________________

Was the deceased a client of NNPCN? YES ☐ NO ☐	**Are you currently being seen by a health care professional/ attending a support group/walk-in?** YES ☐ NO ☐
What are you looking for? Information ☐ Individual Session ☐ Group Session ☐ Anticipatory Grief Support ☐ Other (specify): ☐ ____ **Best time to contact you:** Morning ☐ Afternoon ☐ Evening ☐	**Name/Phone of Client's Health Care Professional(s)** Medical/Nursing:____________________________________ ☐ ____ Counseling ______________________________________ ☐ AA ____ ☐ Mental Health_____________________________________ ☐ Addictions____ ☐ Other (specify) ____________________________________ ☐ Taking prescription drugs? ☐ Yes ☐ No

How did you hear about our service? Brochure ☐ Family ☐ Friend ☐ Website ☐ Other (specify) _______________________________

Follow-up needed: YES ☐ NO ☐ **Specify:** Regular ☐ Complex ☐ Other (specify) ____

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Additional Information on Reverse ☐

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

Intake Date	**Intake by**	
Telephone Support ☐	Discharge Date	Discharge by
Information Session ☐	Discharge Date	Discharge by
Individual Session ☐	Discharge Date	Discharge by
Group Session ☐	Discharge Date	Discharge by
Re-contact Yes ☐ No ☐	**Archive Date**	**Archived by**

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