

**Hospice Niagara
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): _____

Program Requested:

- Adult support group Grief Walk Children, Pre-teen & Parent/Guardian support group
 Adolescent programs Bereavment Visiting Volunteer

Relevant Information Pertaining to Referral:

Name of Deceased: _____
Deceased is the _____ (relationship) to the bereaved
Date of Death: _____
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: _____

Return to: Melissa Penner, Bereavement Advisor via mpenner@hospiceniagara.ca or fax

Serving Families in Niagara

Hospice Niagara - The Stabler Centre

403 Ontario Street, Unit 2
St. Catharines, ON L2N 1L5
T: 905-984-8766 | F: 905-984-8242



Hospice Niagara - Welland

Office
555 Prince Charles Drive
Welland, ON L3C 6B5