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