

Bereavement Support Program Referral Form

Referral Date:

First Name: _____ Last Name: _____
Address: _____ City: _____
Postal Code: _____ Phone: _____
Email: _____
Date of Birth/Age: _____ Male/Female/Identifying: _____
Name of Parent/Guardian Phone (if different): _____
(if child/teen): _____

Program Requested:

- Grief Circle** (adult) Location: St. Catharines Welland Niagara Falls **Mindfulness Hike**
 Grief Walk Location: North St. Catharines Thorold (Central) Welland (South) **Bereavement** **Visiting Volunteer**
 Family Support Group (ages 6 – 13 & guardians) **Preteen Thrive** One day Event (ages 11 – 13 Elementary Students)
 Teen Support Group **Teen 2 Teen:** One day event (ages 14 – 18 Secondary Students) **Bereavement** **Visiting Volunteer**

Relevant Medical information

Medications: _____ Activity Restrictions: _____

Allergies: _____ Vegetarian Vegan Gluten Free Dairy Free Nut Free

Relevant Information Pertaining to Referral:

Name of Deceased: _____ Date of Death: _____

Deceased is the _____ (relationship) to the bereaved 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: _____