HOSPICE NIAGARA
helping **you** live well

Bereavement Support Program Referral Form

Referral Date: ____________________

First Name: ____________________ Last Name: ____________________

Address: ____________________ City: ____________________

Postal Code: ____________________ Phone: ____________________

Email: ____________________

Date of Birth: ____________________ Male/Female/Identifing:

Name of Parent/Guardian (if child/teen): ____________________ Phone (if different): ____________________

Program Requested:

☐ **Grief Circle** (adult) Location: ☐ St. Catharines ☐ Welland ☐ Niagara Falls ☐ Virtual ☐ **Mindfulness Hike**

☐ **Grief Walk** Location: ☐ North St. Catharines ☐ Thorold (Central) ☐ Welland (South)

☐ **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)

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: ____________________

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☐ Permission given by individual for Hospice Niagara's Bereavement Advisor to contact them.

Referral from:____________________ Organization:____________________

Contact Information:____________________ Signature: ____________________