# GREATER TRAIL HOSPICE SOCIETY

**GRIEF REFERRALS: 250-231-7344**
**Office Phone**: (250) 364-6204 **Fax**: (250) 364-6218
Kiro Wellness Center, # 7- 1500 Columbia Ave, Trail, BC, V1R 1J9

## Grief & Bereavement Referral Form

**CLIENT NAME**:_____ Date: _____

Birth Date: _____ Age: _____ Marital Status: _____

Mailing Address: _____

Phone: _____ Mobile: _____

Email Address: _____

What is the best way to reach you: ☐ Phone ☐ Mobile ☐ Email

**Emergency Contact**:_____
NAME PHONE NUMBER

## Referral Information

**Source of Referral**: _____
NAME PHONE NUMBER

**Permission given to contact this client?** ☐ Yes ☐ No

**Is the client interested in support group?** ☐ Yes ☐ No

**Is the client interested in one on one support?** ☐ Yes ☐ No

**Primary reason(s) for referral:** _____

_____

_____

_____

**Relationship to the bereaved:** _____

**Date of death of loved one:** _____

**Cause of death of loved one:** _____

**Others in family requesting/requiring support:** _____

_____

_____

_____

**All Information on this form is strictly personal and confidential and for exclusive use by the Greater Trail Hospice Society**

Revised August 2020

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**Health care professional comments and concerns:**

**Personal information that will help care for this client:**

Intake Notes:

Comments:

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