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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