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| **Barnsley CYPF Bereavement Service** |
| Barnsley CYPF Bereavement Service supports with parents/carers who are bereaved by the loss of a child. The service can provide information, advice, support and counselling.  **PLEASE NOTE**: If you are unsure whether an adult would benefit from support from the Bereavement Counselling Service, please call our duty team on **01904 666371** (Monday – Thursday 9am to 5pm / Friday 9am to 4.30pm). |
| **Privacy Notice Statement & CONSENT** |
| **Please note by completing this referral, Compass will expect the following (please tick to confirm):**   1. This request for support has been discussed and agreed by the service user 2. You consider the person to have capacity to give informed consent 3. You have explained that any information held on this form will be stored by Compass on a secure database   **PLEASE NOTE: If the boxes above have not been completed, you will need to confirm these before a referral will be processed.**  Signed by referrer:………………………………………….… Signed by referred adult:………………………………………… |
| |  |  | | --- | --- | | **CONTACT DETAILS OF REFERRER** | | | **Name:** | **Relationship to referred person:** | | **Organisation (if applicable):** | | | **Address:** | | | **Referrer’s contact phone number:** | | | **Referrer’s email address:** | | | **Have you spoken with a MHST duty worker?** Yes  Who?......... No | | | **How did you hear about the Bereavement Counselling Service?** | | |
| |  |  |  | | --- | --- | --- | | **CONTACT DETAILS OF THE PERSON REFERRED** | | | | **Full name:** | | **Preferred name/pronoun:** | | **Address:** | | | |  | | **Postcode:** | | **Mobile phone number/landline number:** | | | | **Date of birth:** | | **Age:** | | **Gender:** | | **Religion:** | | **Ethnicity:** White British  White other  Mixed  Asian or Asian British  Black or Black British  Other Ethnic Groups  Not known  Other  **If other, please specify: ……………….** | | **Main Language:**  **Is an interpreter required?** Yes / No  **Documents required in main language.** Yes/No | | **Next of Kin:** | | | | **Does the person live alone?** | | | | **Are there any methods by which the person does NOT want to be contacted?** (Unless stated otherwise we will call, text, email and send letters when relevant) | | | | **ABOUT THE BEREAVEMENT** | | | | **Who has died? Name** | **Relationship** | | | **Age at time of death** | **Date of bereavement** | | |
| |  | | --- | | **GP DETAILS** | | **GP Name:** | | **Name and Address of G.P Surgery:** | | **Phone Number:** | | **Email address:** | |
| |  | | --- | | **Please give a brief summary of the bereavement and impact on the person REFERRED.**  (What is the reason for referral? What is the impact of the bereavement on the person referred?) | |  | |
| |  | | --- | | **WHAT IS THE VIEW OF THE PERSON REFERRED?**  (What would they like to achieve from bereavement counselling?) | |  | |
| |  | | --- | | **ARE YOu AWARE OF ANY CURRENT OR PREVIOUS RISKS?**  (Please include risk to self, others and/or safeguarding concerns, appropriate for home visits. (Please attach any current or previous risk assessment if applicable) | |  | |
| |  | | --- | | **Please list any other agencies involved in supporting the person THROUGH BEREAVEMENT** (Please list contact names/numbers if known) | |  | |
| |  |  |  | | --- | --- | --- | | COMPASS MHST OFFICE USE ONLY | | | | Date referral received | Received via which channel | Duty Worker | |  |  |  | |
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| ONCE COMPLETE PLEASE SEND THE COMPLETED FORM TO:   |  |  | | --- | --- | | **Email (MUST BE SECURE):** | **Postal address:** | | **Secure\* email address:** [**info**.**barnsleymhst@Compass-uk.org**](mailto:info.barnsleymhst@Compass-uk.org)  \*NB In order for this to remain secure you must use an EGRESS email address to send the referral | **Compass MHST**  **YMCA building, 1st Floor, 1 Blucher Street, Barnsley, S70 1AP** | | **Secure\* email address:** [**compass.barnsleymhst@nhs.net**](mailto:compass.barnsleymhst@nhs.net)  \*NB In order for this to remain secure you must use an NHS email address to send the referral | | *If you are unable to send the referral securely, please send via post or contact Compass MHST duty line on the number below.* | | **Telephone number – 01904 666371** | |  |  | | --- | | Following receipt of your request for service.   1. Compass MHST allocation meetings are held weekly. 2. Once the request has been to allocation one of the team will be in touch with the referrer regarding the outcome and next steps (if applicable) 3. If Compass MHST accepts the request the person will be allocated a Bereavement Counselling practitioner who will then carry out an assessment to assess the most appropriate intervention/s 4. Interventions are a maximum of 8 – 10 sessions. 5. Progress is reviewed at each session. |   **If you have any questions, you can call the duty line on 01904 666371. Monday – Thursday 9am to 5pm, Friday 9am to 4.30pm** |