BEREAVEMENT SUPPORT

We support families who live within our catchment area of Barnet, Camden, Enfield, Haringey, Islington or Hertsmere, for a period of three years and three months following the death of a child. We will consider referrals from outside our catchment area in exceptional circumstances, on a case by case basis.

All referrals for bereavement support will be considered at our next multidisciplinary panel meeting which will be within two weeks.

If we have all the information needed to make a decision of acceptance promptly, we will allocate someone from our Bereavement Support Team who will contact you to arrange a home visit to start the assessment process.

**If you are referring on behalf of someone, please ensure the referred has consented to and signed this referral.**

# PLEASE TELL US ABOUT YOUR / THIS FAMILY

**Details of the baby/child/young person that has died**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **First name** |  | | **Surname** | |  | | |
| Date of birth |  | Date of death |  | Place of death | |  | |
| NHS No |  | | Gender (Male/Female/Non-binary) | | | |  |

**Parent/carer details**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Last name** | | **First name** | | **Title** | **DOB** | | **Relationship to child** | | |
|  | |  | |  |  | |  | | |
| Address |  | | Borough | |  | | | Postcode |  |
| Religion and ethnicity | |  | | | Tel no. |  | | | |
| Primary language(s) | |  | | | Email |  | | | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Last name** | | **First name** | | **Title** | **DOB** | | **Relationship to child** | | |
|  | |  | |  |  | |  | | |
| Address |  | | Borough | |  | | | Postcode |  |
| Religion and ethnicity | |  | | | Tel no. |  | | | |
| Primary language(s) | |  | | | Email |  | | | |

Interpreter required? Yes  No

**Sibling’s details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Last name** | **First name** | **DOB** | **Male/Female/Non-binary** | **Who has parental responsibility?** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

# REASON FOR REFERRAL

|  |
| --- |
|  |

**If there are any current or previous safeguarding concerns please give an outline, including allocated Social Worker contact details:**

|  |
| --- |
|  |

**IF RELEVANT please tell us if siblings are subject to any of the following:**

Child Protection plan  Child in Need plan

Care Order  Child Arrangements Order

Special Guardianship  Child in Care; by voluntary agreement

# PROFESSIONALS’ DETAILS

**General practitioner**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| GP name |  | Telephone | |  | | |
| Address |  | | | | Postcode |  |
| ICB |  | Email |  | | | |

**Professionals involved**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name and title** | **Address** | **Telephone** | **Email** | **Type and frequency of support and service provided** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Please share any other information you feel would be helpful:**

|  |
| --- |
|  |

**Referrer’s details**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Full name |  | | | Role/relationship to child | | |  |
| Address |  | | | | | Postcode |  |
| Tel no. |  | | Email | |  | | |
| Date of referral | |  |  | | | | |

**How did you hear about Noah’s Ark?**

Already working in partnership  Local professional networking

Noah’s Ark presentation  Noah’s Ark fundraising event

Family or friend  GOSH crèche/music therapy service

Other, please state:

|  |
| --- |
|  |

**CONSENT TO REFERRAL AND CONSENT TO SEEK AND SHARE INFORMATION**

In order to provide safe and effective care, Noah’s Ark Children’s Hospice may need to share up to date personal details, and social care information, with other professionals including (but not limited to) community teams, GPs, hospitals, local authorities and/or clinical commissioning groups.

**I consent to the referral and give permission for Noah's Ark Children's Hospice to seek and share health and social care information as necessary, as outlined above.**

Yes  No

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer’s signature |  | Date |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Parent/Carer’s signature |  | Date |  |

Please send the completed form to us by post or email. If you are emailing outside of the nhs.net network, please note that this is not secure so please password protect the sent documents and send the password in a separate email.

Post: **The Ark, Byng Road, Barnet EN5 4NP** | Email: [**noahs.referrals@nhs.net**](mailto:noahs.referrals@nhs.net)

Urgent referrals for care after death through Noah’s Ark Children’s Hospice can be directed to the 24/7 Nurse-on-Call number: 020 3994 4134. Please leave a message and your call will be returned within 1 hour.

The on-call Registered Nurse can advise on the referral immediately or plan a call back following discussion with the Referral Panel Members. Please email urgent referral forms to [noahs.nurses@nhs.net](mailto:noahs.nurses@nhs.net)