6 Albert Street, Parry Sound, ON P2A 3A4
Phone: (705) 746-4540 ext.1415 Fax: 705-773-4098
E-mail: jcaux@parrysoundhospice.ca Website: parrysoundhospice.ca

NEW Bereavement Client– REFERRAL FORM

Please fill in the following client information and fax to 705-773-4098

CLIENT INFORMATION:

Name:	**DOB:**
Address:	**Phone number:**

Reason for referral:	Please check off what is applicable. ☐ Grief ☐Depression ☐Anxiety ☐Respite ☐Failure to Cope ☐ Group Interest ☐Information ☐Recent Death ☐Anticipated Death ☐Caregiver Burnout	**Referred by:** **Name:** **Number:** **Email:** **Agency:**

Name of deceased/dying: **Date of Death:** **Cause of Death:**	**Family Doctor:** **Contact info:**	**Has client consent for Hospice referral been obtained?** Yes ☐ No ☐ **Name:** **Signature:**

Medications Yes ☐ No☐	**List medications :**

Additional information: (psychosocial concerns, disabilities, etc.)

Emergency Contact:	**Relationship:**	**Phone number:**