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**Referral form for the Bereaved by Suicide Service in**

**Suffolk and North East Essex**

 Please complete as much of the referral form below as possible.

|  |  |
| --- | --- |
| Name of the individual being referred  |  |
| Gender |  |
| Ethnicity |  |
| Religion |  |
| First language |  |
| Date of birth |  |
| Preferred Telephone Number |  |
| Address |  |
| Email |  |
| School  |  |
| Parent Details  |  |
| Parental Consent  |  |
| Relationship to deceased |  |
| Name of deceased  |  |
| Date of birth of deceased  |  |
| Date of incident/date of death if different |  |
| Date of referral |  |
| Method of suspected suicide |  |
| Location of suspected suicide |  |
| Did the individual being referred discover the deceased? |  |
| Is the individual being referred currently in receipt of support from other services? Please list. |  |
| Are there any additional needs or disabilities to be aware of? |  |
| Are there any potential risks that a bereavement support case worker should be aware of when visiting the home address? |  |
| Additional information to maximize support |   |

Has consent to contact the individual been given? YES/NO

Who was it obtained by?

**Name:**

**Position:**

**Organisation:**

**Email:**

Please email this form to SNEE.bereavedbysuicide@victimsupport.org.uk