

EMOTIONAL SUPPORT REFERRAL FORM



Jersey Hospice Care
your care, your choice, your time

Please tick box to confirm <input style="width: 40px; height: 20px;" type="checkbox"/>	GDPR Consent Statement Has the person you are referring for support consented to Jersey Hospice Care contacting them and recording their details? If they do not give their consent, we cannot contact them to offer support service. They have the right at any time in the future to withdraw their consent. We confirm that this information will not be passed to any third parties.		
YOUR DETAILS	Name:	Role and organisation/relationship to the person named below:	
DETAILS OF PERSON BEING REFERRED	Name:	Emis number:	Date of birth:
Address:			
Post code:			
Email:			
Telephone:	Mobile:	Home:	
GP name and surgery			
Preferred language		Preferred method of initial contact: Text/email/telephone	
NATURE OF REFERRAL			
Individual/couple/family support (circle)	Name and dates of birth of other members to be supported:		
Relationship to the patient if a family member/friend:		Name of patient of JHC and Emis no:	
Brief description of the life limiting illness			When was the diagnosis:
Main worries and concerns at present			
SERVICE LEAFLET GIVEN <input style="width: 40px; height: 20px;" type="checkbox"/>	Please return by hand, email bereavement@jerseyhospicecare.com or post to Community Bereavement Service, Clarkson House, Mont Cochon, St Helier, JE2 3JB.		Date received: