H.U.U.G. Children's Grief Referral Form

Please return completed form by email or fax to: **fax: 905-712-4029**
E-mail: info@hearthousehospice.com
Telephone: 905-712-8119

Referral Date:

REFERRER INFORMATION:

Name of Referrer:	
Organization:	
Phone:	
Email:	
Profession: ☐Nurse ☐Physician ☐Social Worker ☐Family ☐Other:	

CHILD/REN INFORMATION

Name of Child	**Age**	**Gender**	**Relationship to patient**	**Lives with patient**	**Referr for services**	**Informed of Diagnosis**	**Informed of Prognosis**
		☐M☐F		☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
		☐M☐F		☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
		☐M☐F		☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N
		☐M☐F		☐Y ☐N	☐Y ☐N	☐Y ☐N	☐Y ☐N

FAMILY INFORMATION

Name of dying/deceased:		☐Male ☐ Female ☐Dying☐Deceased
Relationship to child/ren:		
Date of Birth: (mm/dd/yyyy)		
Date of Death:	☐ N/A	
Diagnosis:		
Prognosis or Cause of Death		

Name of Guardian/Custodian:	
Relationship to child/ren:	
Primary Phone:	
Alternate Phone:	
Address:	
Family's Primary Language:	

SCHOOL INFORMATION

Has the child's school been notified?	☐Y ☐N ☐Unknown
Name of school	
Phone number of school	

Other adults involved with child/ren	**Relationship to child/ren**	**Lives with child/ren**	**Informed of Diagnosis**	**Informed of prognosis**
		☐Y ☐N	☐Y ☐N	☐Y ☐N
		☐Y ☐N	☐Y ☐N	☐Y ☐N
		☐Y ☐N	☐Y ☐N	☐Y ☐N

Reason(s) for Referral:
Relevant family/custody information:
Relevant religious or cultural practices: