

**BEREAVEMENT REFERRAL**

Name of deceased: \_\_\_\_\_ P# \_\_\_\_\_ Date of death: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Location: HC HIU PCU/SWING BED

**Primary Caregiver:** \_\_\_\_\_ **Relation to patient:** \_\_\_\_\_

Address of PCG: \_\_\_\_\_

Phone number: \_\_\_\_\_ Directions: \_\_\_\_\_

Staff needed to accompany on visit  Yes  No \***NEED FOR EARLY CONTACT  Y  N**

**Observations/Assessment**

estranged relationships \_\_\_\_\_

other stresses on family \_\_\_\_\_

coping problems of family member(s) \_\_\_\_\_

caregiver/family reactions at time of death \_\_\_\_\_

minor children in the home \_\_\_\_\_

HBI staff not present at time of death \_\_\_\_\_

**Circumstances surrounding the death  UNKNOWN**

symptom control  good  poor \_\_\_\_\_

peaceful  traumatic \_\_\_\_\_

recent diagnosis and death \_\_\_\_\_

persons in attendance at death \_\_\_\_\_

**Primary caregiver with the following: Explain:**

Hx of mental illness \_\_\_\_\_  Hx of suicide threats or attempts \_\_\_\_\_

Hx of substance abuse \_\_\_\_\_  No support system \_\_\_\_\_

Immediate financial or legal needs \_\_\_\_\_  Other \_\_\_\_\_

Comments: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

White copy: LTC

Yellow:

