**We recognise that this form asks for quite a lot of information which helps us to understand your needs and ensure that we are the right service for you. If you need any help completing this form – please get in contact with us on 07483 368700 or** **supportaftersuicide@rethink.org** **and we can complete this form with you during a phone call or you can ask someone else to complete this on your behalf**

**Contact Details**

D.O.B:

Name:

Title:

Referrers name & service name

Please can you identify below whether you have any information or communication support needs relating to a disability, impairment or sensory loss. If you tick any of the boxes below – we will contact you to discuss, how we can best communicate with you

Mental Health

Sensory

Physical

Learning

Address:

Main Telephone No:

2nd Telephone No:

Town:

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­­

County:

Post Code:

@

E-Mail:

Name:

Emergency Contact Details:

­­

Telephone No:

 **Demographic Information**

Ethnicity:

Sexual Orientation:

Gender:

Marital

Status:

Religion::

Which Borough do you live in?:

 **Bereavement Information**

Relationship to the person you

have lost

Length of time since bereavement

Anniversary of bereavement – We ask this so we can offer you support at this difficult time

We support people who are bereaved by suicide who live, work or study in Camden, Islington, Enfield, Haringey and Barnet and we support people who live outside of the boroughs butare bereaved by a suicide whichoccurred within these 5 boroughs**. If you do not live in one of the 5 boroughs – did your bereavement occur within the boroughs?**

Yes

No

What sort of support do you feel you need?

121- and Group Based Support

Group Based Support

121 Support

The majority of support will be provided Monday – Friday 9am-5pm – however we can provide support up to 8pm in the evening for people who work or study during the day. Do you need support to be delivered between 5pm-8pm?

No

Yes

Referral Date:

Signed:

How would you like us to make initial contact with you?

E.g Phone, Post, Text, Email.

**Preferred Method of Contact**

Please give details of any other support services you receive e.g. counselling, mental health support etc

Name of your GP Practice

**Other Support Services**

Do you have any concerns about your own safety or feel at risk from anyone? Do you have any concerns for anyone else’s safety. If yes please tell us about this below

Please Give a Brief Description of your current situation, How are you feeling / coping? What difficulties are you experiencing? What sort of support do you feel would help you?

If you answered Yes – please tell us about their age, if they live with you and any concerns you have for them at present?

Yes

No

Do you have responsibility for any children and young people?