Support After Suicide Service Referral Form

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

Title: Name: D.O.B:

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

Learning Physical Sensory Mental Health

Address:

Main Telephone No:

Town:

County:

2nd Telephone No:

Post Code:

E-Mail: @

Emergency Contact Details: Name:

Telephone No:

Demographic Information

Ethnicity: Sexual Orientation:

Religion Gender:

Marital Status: 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 but are bereaved by a suicide which occurred within these 5 boroughs. **If you do not live in one of the 5 boroughs – did your bereavement occur within the boroughs?** Yes No

Please return this form to supportaftersuicide@rethink.org or by post to Charlie Ratchford Centre, Belmont Road London NW1 8HF

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What sort of support do you feel you need?

121 Support ☐ Group Based Support ☐ 121- and Group Based 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?

Yes ☐ No ☐

Do you have responsibility for any children and young people? Yes ☐ No ☐

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

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?

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

Other Support Services

Name of your GP Practice

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

Preferred Method of Contact

How would you like us to make initial contact with you?
E.g Phone, Post, Text, Email.

Signed:

Referral Date:

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