**Suicide Bereavement Support Service – Third Party Referral Form**

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| **1. Details of Referred Person** |
| **Name** |  |
| **Address** |  |
| **Date of Birth** |  |
| **Telephone Contact(s)** |  |
| **Email Address (optional)** |  |
|  |  |
| **Advise phone call within 24hrs is default contact method. Alternative instructions for contact (email, text etc) -** |
|  |
| **Best Time to Contact** | **Anytime** | **[ ]**  | **Morning** | **[ ]**  | **Afternoon** | **[ ]**  |

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| **2. Referrer’s details** |
| **Name of Referrer**  |  |
| **Job title** |  |
| **Referring agency** |  |
| **Contact details** |  |

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| **3. Details of the deceased** |
| **Name** |  |
| **Date of birth** |  |
| **Date of suicide** |  |
| **Location of suicide** |  |

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| **4. Further Information** |
| **Relationship of referred person to the deceased -** |
| **Please provide a brief overview of the circumstances and method of suicide (this is to ensure that the referred person does not have to repeat traumatic details)** |
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| **Has the referred person given consent for the referral to be made?** | **Yes** | **[ ]**  | **No** | **[ ]**  |
| **Has a service leaflet been given to the person being referred?** | **Yes** | **[ ]**  | **No** | **[ ]**  |

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| **5. Risk** |
| **If there any known risks to self (e.g. suicidal thoughts, self harm), from others (e.g. physical, sexual, emotional etc), or to others (eg. violence, aggression), please detail below:** |
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| **Signed (referrer)** |  |

**Please email this form to suicidebereavementsupport@nhs.scot**