**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)** | | | | |
|  | | | | |
| **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:** |
|  |

|  |  |
| --- | --- |
| **Signed (referrer)** |  |

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