|  |  |
| --- | --- |
| **Child’s name:** | **Referral date:**  |
| **Date of birth:** | **Current age:**  | **Gender:** | **Ethnic group:**  |
| **Referred by:** | **Relationship to child:** |
| **Referrer’s telephone:**  | **Referrer’s email:** |
| **Referrer’s contact address:** |
| **Parent/carer’s name(s):****Address:****Telephone:****Email:****Has parental consent been obtained? Y/N** | **School contact (if known):****School name:****Address:****Telephone:****Email:** |
| **What bereavement has the child experienced?** |
| **What support is the child currently receiving?** |
| **Child’s presenting issues:** |
| **Which intervention(s) would support this child? (Select as many as appropriate)*** **1:1 Bereavement Therapy**
* **Peer Support Day**
* **School Support**
* **Family Support**
 |
| **What differences would you like to see as a result of the child accessing support through OWLS?** | **1.** |
| **2.** |
| **3.** |
| **4.** |
| **How did you hear about the OWLS Bereavement Service?** |  |