Gloucestershire Support After Suicide Service

REFERRAL FORM

It is really important that we fully understand your needs and ensure that we are the right service for you and it is for this reason, that we ask for so much information. If you would like some help completing this form, you could ask someone else to complete this on your behalf. Or you can get in touch with us and we can complete this for you during a phone call.

You can call us Monday – Friday 9am-8pm on 07483 375516. You can also call the Rethink Gloucestershire Self Harm Helpline any day, between 8pm and 10pm, where the team can take a referral for the Glos Support After Suicide Service - 0808 801 0606 or you can email us at glossupportaftersuicide@rethink.org

Contact Details

Title: Name: D.O.B:

Referrers name & service name

Using the boxes below, please tell us if would like to receive support using a specific language or/and you have any other support needs.

Language Which language? Learning Physical Sensory Mental Health

Address: Main Telephone No:

Town:

District:

Post Code:

E-Mail: @

Emergency Contact Details: Name:

Telephone No:

We want to make sure our service is accessible to everyone. Completing the following information really helps us to improve upon this. Completing this is optional. If you do decide to complete this - thank you.

Ethnicity: Sexual Orientation:

Religion Gender:

Marital Status:

Bereavement Information

Relationship to the person you have lost

Are there any special dates or events where you feel you might like to have some additional support?

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What support do you feel might help you at the moment? (Tick all that apply)

121 practical & emotional Support ☐

Bereavement Peer Support Groups ☐

Bereavement Counselling ☐

Online Bereavement Peer Support Message Boards ☐

Would you like to receive face to face support or virtual support by phone/video call?

Face to Face ☐ Virtual ☐

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 use the box below to tell us a little bit about how you are feeling and coping, at the moment?

Do you have any concerns about your own safety or feel at risk from anyone? Do you have any concerns about the safety of someone else? 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?

I confirm that I agree to Rethink Glos Support after Suicide service to hold information about me, and to share or exchange information with other service providers about me and on my behalf in order to provide me with support.

Name:

Signed: Referral Date: