support in mind scotland
action for people affected by mental illness

penumbra
your way to a brighter future

**Suicide Bereavement Support Service**
**Self-Referral Form**

| **Who you are** | | | |
|---|---|---|---|
| **Name** | | | |
| **Address** | | | |
| **Date of Birth** | | | |
| **Telephone Contact(s)** | | | |
| **Email Address (optional)** | | | |
| **Default contact method - You should expect an initial phone call within 24hrs of us receiving this referral. Alternative instructions for contact (email, text etc) can be made. Please outline any preference below.** | | | |
| | | | |
| **Best Time to Contact** | **Anytime** ☐ | **Morning** ☐ | **Afternoon** ☐ |

| **Details of the deceased** | |
|---|---|
| **Name** | |
| **Date of suicide** | |
| **Location of suicide** | |

| **Further Information** |
|---|
| **Your relationship to the deceased -** |


Suicide Bereavement Support Service
Suicidebereavementsupport@nhs.scot
0800 4714768

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| Further Information | | |
|---|---|---|
| Please provide a brief overview of the circumstances and method of suicide (this is to ensure that you do not have to repeat traumatic details) | | |
| | | |
| Please give your consent for us to provide you with support and store your data | Yes ☐ | No ☐ |

| Signed | |
|---|---|

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

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