Suicide Bereavement Support Service – Third Party Referral Form

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 ☐

2. Referrer's details	
Name of Referrer	
Job title	
Referring agency	
Contact details	

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

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** ☐

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

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0800 4714768