The Elizabeth Hospice

Appendix: A

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REFERRAL FOR GRIEF AND LOSS SERVICES

Date: _____

School: _____ **School District:** _____

Point Person: _____ **Title:** _____

Phone: _____ **Email:** _____

I am interested in:

☐ On-site 8-week grief support group (a minimum of 8 students have been identified)

☐ I am looking at a start date of (check one): ☐ Oct-Dec ☐ Jan-Mar ☐ Mar-May

☐ Individual Counseling*/includes counseling for bereavement and a serious illness
(This family is expecting a call from your agency) - * *This is a fee-based service*
Guardian's name: _____ Phone Number: _____
Child's name: _____ Grade: _____
Child's name: _____ Grade: _____
Is this family Spanish speaking only? ☐ Yes ☐ No

☐ Resources/Information on services, upcoming trainings, and events

☐ Yes, please sign me up to receive informational emails and event invitations.

Office Use: