

**Family Support Service Referral Form**

The family support service supports children, young people and families where there is impact from a significant adult’s cancer diagnosis or effects from living with cancer. The adult could be a parent, Grandparent, Aunt, Uncle, etc. The service uniquely meets the needs of each individual family.

|  |  |
| --- | --- |
| **Referral date** |  |

**Family Details**

|  |  |  |
| --- | --- | --- |
| **Name of Parent** |  | |
| **Name of Parent** |  | |
| **Address** |  | |
| **Phone** |  | |
| **Email** |  | |
| **Name of person with diagnosis** |  | |
| **Relationship to children** |  | |
| **Details of diagnosis (e.g. date, type, prognosis)** |  | |
| **Reason for referral**  **(please continue on reverse if needed)** |  | |
| **Any other agencies involved** |  | |
| **Children’s Names** | **DOB** | **Issues** |
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|  |  |  |
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**Referrer’s Details**

|  |  |  |
| --- | --- | --- |
| **Name** |  | |
| **Role** |  | |
| **Organisation** |  | |
| **Phone** |  | |
| **Email** |  | |
| **I confirm that the parent/carer gave consent for this referral** | | Y N |

**Support Requested (tick all that apply)**

|  |  |  |  |
| --- | --- | --- | --- |
| One to one support – home |  | Youth Group (12-18) |  |
| One to one support – school |  | Parent Carers Group |  |
| Phone/online support |  | Parent Bereavement Group |  |

**Signature of parent or carer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please return to Gail Calwell, Family Support Coordinator :*** [*gailcalwell@cancerfocusni.org*](mailto:rachelsmith@cancerfocusni.org)