

**Brent, Wandsworth & Westminster Mind Referral Form  
Suicide Bereavement Liaison Service North and South West London**

- ❖ If you need support in completing this form, ask your GP to help or contact us at [sbls@bwwmind.org.uk](mailto:sbls@bwwmind.org.uk)

**Date of Application/Referral**

Day	Month	Year

**Referrer's Details**

First Name(s)	Last Name	Position/Role
Address (line 1)		
Address (line 2)		
Town		
Postcode		
Phone		
Mobile		
Email		

**Applicant/Referral Details**

First Name(s)	Last Name	AKA (if applicable)
Address (line 1)		
Address (line 2)		
Town		
Postcode		
Phone		
Mobile		
Email		

**Other information. (Applicant's date of birth)**

Date of Birth	Age

**GP Name and Address, NHS Number of Referred**

Name of GP	Address & Contact Details
NHS No. (if known)	

## What borough does the Referred/Deceased live in?

	Referred	Deceased
Brent		
Ealing		
Hammersmith & Fulham		
Harrow		
Hillingdon		
Hounslow		
Kensington & Chelsea		
Westminster		
Croydon		
Sutton		
Merton		
Kingston		
Richmond		
Wandsworth		
Other		

## What services would help support you?

Would you be interested in a group support	Please tick
Yes	
No	

Name of Deceased	
Date of Death	
Relationship to the deceased	
Method	

## Accessibility

Access	
Is your/the applicant's first language English?	
If not English, is translation/interpreting required?	
Do you/does the applicant have a disability?	

## Declaration of Applicant

I confirm that the information I have provided is correct. I also consent to my contact information being used by BWW Mind Bereavement Officers to provide support (I am aware that this information can be deleted at any time if requested).

Signed: .....

Date: .....

Send this form back to: [sbls@bwwmind.org.uk](mailto:sbls@bwwmind.org.uk)

**1 MONITORING INFORMATION**

To promote and ensure equal opportunities in all aspects of our service delivery we gather information on everyone applying or and using our services. This information will be treated with strictest confidence.

Please tick the boxes which apply to you/applicant.

<b>Gender/ Sex</b>	Male	Female	Are you the same, gender you were assigned at birth.	Prefer not to say
Please Tick				

<b>Sexuality</b>	Bi-sexual	Heterosexual	Gay or Lesbian	Prefer not to say
Please Tick				

<b>Ethnicity</b>	Asian- Bangladeshi	Asian- Indian	Asian-Pakistani	Asian- Other
Please Tick				
	Black African	Black Caribbean	Black British	Black Other
Please Tick				
	Mixed White & Asian	Mixed White & Black African	Mixed White & Black Caribbean	Mixed Other
Please Tick				
	White British	White European	White Irish	White Other
Please Tick				
	Arabic	North African	Gipsy/Traveller	Chinese
Please Tick				
	Prefer not to say			
Please Tick				

<b>Religion</b>	Christian	Muslim	Jewish	Hindu
Please Tick				
	Sikh	None	Prefer not to say	Other (Please State)
Please Tick				

If you have any questions regarding the referral form please contact Brent, Wandsworth, and Westminster Mind Suicide Bereavement Liaison Team at: [sbls@bwwmind.org.uk](mailto:sbls@bwwmind.org.uk)