Society for the Promotion of Hospice Care

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Bereavement Counselling – Service Application Form

A. Applicant Information

Name: _____ (Eng) _____ (Chi) Gender: F/M

Date of birth: _____ HKID no.:_____ Religion: _____ Occupation: _____

Address: _____

Tel.no.: _____(home)_____(mobile) Email:_____

Have you encountered any of these situations in the last two years?

☐ Death of a loved one (your relationship to him/her: _____)

☐ Miscarriage ☐ Job loss ☐ Retirement ☐ None of the above

☐ Other _____ (Please specify)

Have you received/ been receiving any other counselling services?

☐ Yes (Please specify) ☐ No

1. Position:_____ Name:_____ Contact no.:_____

(Ongoing/ Ended on _____ (dd/mm/yy)

2. Position:_____ Name:_____ Contact no.:_____

(Ongoing/ Ended on _____ (dd/mm/yy)

3. Position:_____ Name:_____ Contact no.:_____

(Ongoing/ Ended on _____ (dd/mm/yy)

B. Information of the deceased

Relationship to the applicant:	☐ Spouse ☐ Parent ☐ Child ☐ Siblings ☐ Boyfriend/Girlfriend ☐ Other _____ *(please specify)*
Date of death:	_____
Cause of death:	☐ Accident _____ *(please specify)* ☐ Chronic illness ☐ Acute disease ☐ Suicide ☐ Homicide ☐ Other _____ *(please specify)*

C. Service expectations

Are there any particular issues you would like to work on with us in the counselling sessions?

_____

_____

_____

D. Emergency Contact Information

1. Name:_____ Relationship:_____ Phone: _____
2. Name:_____ Relationship:_____ Phone: _____

Applicant signature: _____ Date: _____