OCEANS Grief and Loss Programme

North Otago Self-Referral Form

Date: _____

Contact Name: _____

Contact Phone: _____ Contact Email: _____

Client/Child(ren's) Details

Name: _____ DOB: _____ M/F

Name: _____ DOB: _____ M/F

Name: _____ DOB: _____ M/F

Relationship to Client: _____

Briefly describe the loss/grief:

_____

_____

_____

_____

_____

_____

When did the loss occur? : _____

Please number in order of preference your choice of days that suit you for meetings:

Mon: ☐ Tues: ☐ Wed: ☐ Thurs: ☐ Fri: ☐

Please indicate what times you would be available for meetings:

Mornings: ☐ Afternoons: ☐ Evenings: ☐

Please forward either by email to OCEANS.Oamaru@FamilyCare.org.nz, or by mail to:

Maria Johnson
OCEANS Programme Coordinator
Anglican Family Care
23 Coquet Street
Oamaru 9400