

UNIT STAFF – COMPLETE AND PROVIDE TO BEREAVEMENT COORDINATOR

Bereavement Coordinator Name _____

Unit _____

(Sticker) NAME _____
MRN _____ SEX _____
ADMIT DATE _____

BEREAVEMENT FOLLOW-UP CHECKLIST

Patient Information: Primary Language Spoken _____

Patient's Date of Birth _____ Marital Status Single Married Widowed/Divorced

Date and cause of death _____

Patient Care Unit/location where death occurred _____

RN and MDs caring for patient at the time of death _____

Other Patient Care Units/staff involved during dying process _____

Chaplain Involved:Yes No / Autopsy granted: Yes No / Organ Donation:Yes No
(Page Chaplain on call with any questions or concerns)

Family Information:

Was family present at time of death Yes No

Describe any blessings/issues/concerns/family reaction:

Was family provided Bereavement Packet Yes No

Family name(s) and address (s)

Phone _____

Phone _____

Relationship to pt _____

Relationship to pt _____

Sympathy Card sent to(sent 1st week to 1st month after death): _____

Date _____ By: _____

Correspondence/Calls from Family? No Yes _____

6 Week Follow up sent to (*optional*): _____

Date _____ By: _____

Correspondence/Calls from Family? No Yes _____

1 Year Follow up sent to(sent on or around the 1st anniversary): _____

Date _____ By: _____

Correspondence/Calls from Family? No Yes _____

Holiday Information provided (*optional October –December*) Yes No

Comments:

DO NOT SEND THIS FORM TO THE STAFF ADMINISTRATOR
File according to unit procedures and provide information to Quality Coordinator