Grief Support Intake Form

URGENCY ___/10

PLEASE PRINT: Date: _____

Name: (first)_____ (last)_____

Date of Birth: (dd/mm/yy) _____ Gender: _____ Faith/Religion: _____

Phone: _____ (Alternate): _____

Email: _____

Home Address: _____ PC: _____

Current Location: Home ___ Residential Care Home ___ Hospital ___ Other: _____

Live alone ____ *Young Children in home* _____ *Smoking in Home* ____ *Pet(s)?*_____

Employment: _____ Phone: _____

Are you currently working? _____

Deceased Person's Name: _____ Age: _____

Date of Death: _____ Relationship to You: _____

Other Losses: _____

Circumstances: _____

_____

Power of Attorney for Personal Care if known: _____

Name of Emergency Contact	Relationship	Home Phone	Business/Cell #

Please provide all Providers and Services Currently involved: (if known)

Name	Phone	Fax
Family Physician:		
Nurse Practitioner:		
CCAC:		
Community Nurse: (and agency)		
Other:		

Referred by: _____ **Agency:**_____

Contact Info: _____

What Special Concerns do You want to Address Through Grief Consultation? What are your goals? Please Briefly Explain: _____

_____

_____

_____

Please turn over →

PLEASE **CHECK ALL** OF THE REACTIONS YOU ARE CURRENTLY EXPERIENCING:

____LONELINESS	____ANGER	____GUILT	____FEAR
____RELIEF	____DEPRESSION	____EATING/SLEEP DISTURBANCE	____RESTLESSNESS
____NEGATIVE ATTITUDE	____FATIGUE	____LACK OF MOTIVATION	____ANXIETY
____HOPELESSNESS	____LOSS OF MEANING	____FORGETFULNESS	____JOYLESSNESS
____POOR CONCENTRATION	____DOUBTING BELIEFS	____WORRYING	____MOOD SWINGS
____FEELING FOGGY	____SUICIDAL THOUGHTS OR IDEATION	____SENSE OF ISOLATION	____IRRITABILITY

____DIFFICULTY WITH OTHERS' REACTIONS ____ SHAME ____DIFFICULTY WITH THE WAY OTHERS ARE SHOWING OR NOT SHOWING THEIR GRIEF

WHAT ARE THE BEST TIMES AND DAYS AVAILABLE FOR APPOINTMENTS?

PLEASE CHECK ALL THAT APPLY

( ) MORNINGS (8-11 AM)
( ) AFTERNOONS (12-4 PM)
( ) EVENINGS (5-8 PM)

( ) MONDAY
( ) TUESDAY
( ) WEDNESDAY

( ) THURSDAY
( ) FRIDAY
( ) SATURDAY (AM OR AFTERNOON)

( ) OTHER: _____

IF YOU ARE NOT ABLE TO ATTEND APPOINTMENTS AT OUR OFFICES, EXPLAIN: _____

TERMS AND CONDITIONS

Before submitting this form and utilizing the many support services of Hospice Outreach Programs of Elgin (HOPE) please read these Terms and Conditions carefully. You fully understand that ongoing use of HOPE's services indicates that you agree to the Terms and Conditions summarized below.

DISCLAIMER: SERVICES PROVIDED BY HOPE ARE NOT A SUBSTITUTE FOR MEDICAL ADVICE OR TREATMENT.

CONFIDENTIALITY: YOUR PERSONAL INFORMATION (AS ON THIS INTAKE FORM), AS WELL AS THE CONTENT OF YOUR CONSULTATION SESSIONS WITH A REPRESENTATIVE REPRESENTING HOPE, MAY BE USED IN CASE OF AN EMERGENCY SITUATION ONLY. IN ORDER TO KEEP YOU AND THE COMMUNITY SAFE: WE OFFER CONFIDENTIALITY IN OUR SESSIONS. THIS MEANS THAT WHATEVER YOU SAY IN OUR SESSION WE WILL NOT TELL OTHERS WITHOUT YOUR PERMISSION EXCEPT FOR THREE CONDITIONS:

1. *YOU HAVE A PLAN TO HARM YOURSELF OR SOMEONE ELSE. (THIS MEANS THAT YOU HAVE PLANNED OUT THE EXACT SITUATION WHERE SOMEONE CAN GET HURT, WE HAVE A DUTY TO REPORT THAT.)*
2. *YOU SHARE A PAST OR PRESENT CASE OF CHILD ABUSE THAT HAS NOT YET BEEN REPORTED.*
3. *WE GET COURT SUBPOENAED, WHICH MEANS THE COURT REQUESTS DOCUMENTS OF OUR SESSIONS WITH YOU.*

COMMUNICATION OF PRIVATE MENTAL HEALTH INFORMATION

*PLEASE **(V)** ALL ACCEPTABLE FORMS OF COMMUNICATION TO PROVIDE QUALITY CLIENT CARE:*

□ I AUTHORIZE HOPE'S REPRESENTATIVE TO LEAVE A MESSAGE REGARDING MY PRIVATE INFORMATION ON MY PERSONAL VOICEMAIL/ANSWERING MACHINE.

□ I AUTHORIZE HOPE'S REPRESENTATIVE TO SEND WRITTEN COMMUNICATION TO MY HOME OR EMAIL ADDRESS.

□ I AUTHORIZE HOPE'S REPRESENTATIVE TO SHARE INFORMATION WITH OTHER HEALTH CARE PROFESSIONALS I MAY BE ASSOCIATED WITH, NOW OR IN THE FUTURE, IF HELPFUL TO MY CARE.

□ BY SIGNING BELOW, I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT AND HEREBY GIVE AUTHORIZATION FOR THE RELEASE OF INFORMATION BY THE ACCEPTABLE MEANS CHECKED ABOVE.

PAYMENT: THERE IS NO CHARGE FOR OUR SERVICES. DONATIONS ARE APPRECIATED, BUT NOT REQUIRED.

SIGNED:_____ **DATE:** _____

Client signature or Parent/Guardian signature (if client is a minor or under age 12)