



Please check appropriate box(es):

Support Group Participant

Connections Participant

Heartstrings Participant Information Form

All information on this form will remain strictly confidential.

Date _____ Referral Source _____

Family Information:

Your Name _____ Age _____

Address _____

Telephone (home) _____ (work) _____

Email _____

Occupation/Employer _____

Marital Status (Please circle) Married Single

Spouse/Partner's Name _____ Age _____

Address (if different from above) _____

Telephone (home) _____ (work) _____

Email _____

Occupation/Employer _____

Religious denomination (if applicable) Self _____ Spouse/Partner _____

Language(s) spoken other than English Self _____ Spouse/Partner _____

Please complete the following questions about the loss of your baby. (You may use the back of this page if you need more room or have had more than one loss.)

1. What date did the death of your baby occur? _____
2. Did the death occur during the pregnancy? How far along in the pregnancy were you? _____
 at birth? How far along in the pregnancy were you? _____
 after birth? How old was your baby? _____
3. Did your baby spend any time in the neonatal intensive care unit? Yes No
4. What was the cause of death? _____
5. What is your baby's name? (if applicable) _____

Names of living children (if applicable)	Date of birth	Sex
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Please complete additional questions on the back of this page.)

