Hospice Patient’s Name ______________________
Medical Record # _____________________
Date of Death: ____________________
Ber. Client’s Name: _______________________
Client’s Number: _______________________
Relationship to Deceased: _____________________

BEREAVEMENT NOTE
Rev 09/18

Date of Contact ________________  Length of Contact_____________ (Hrs/Mins)
☐ Condolence call  ☐ Wake  ☐ Funeral  ☐ Support call
☐ Assessment  ☐ 3 Month  ☐ 6 Month  ☐ 9 Month  ☐ 12 Month  ☐ Closure
☐ Telephone  ☐ Home Visit  ☐ Office Visit  ☐ Note  Other____________________________

Problems Discussed
Please check off any subject area discussed with the bereaved.
Note: Anything checked off must be addressed in the “summary” section below

☐ Appropriate Grief Reactions  ☐ Crying/Sadness  ☐ Changes- Eating/Sleep
☐ Guilt  ☐ Lack of Support  ☐ Transportation Needs
☐ Denial  ☐ Financial Concerns  ☐ Health Concerns
☐ Anger  ☐ Spiritual Concerns  ☐ Children’s Reactions
☐ Loneliness  ☐ Alcohol/Drug Use  Other____________________________

Summary of Contact
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________

Plan
☐ Additional follow-up by_______________________________ in ______ weeks/months
☐ Routine mailings
☐ Referrals made to:___________________________________________
Other____________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
Date_________ Volunteer Signature____________________________

Reviewed by Bereavement Coordinator: (Date and Initials)______________
Scanned into EMR: _______________ (Date)