



**The goals of Hospice of San Joaquin’s Bereavement Services are:**

- to provide you with information about the normal grief process;
- to offer you an opportunity to review and reflect on the experience of caring for your loved one and your loss experience;
- to assess and monitor individual coping ability, stress levels, and available support;
- to encourage you to utilize existing support systems and/or to seek and create additional sources of support; and,
- as appropriate, to recommend effective methods for coping with and adjusting to the loss.

**Information shared by our clients during phone conversations and support sessions will be held in confidence except when the following legal limitations apply:**

1. When the client threatens bodily injury to another or is suicidal.
2. When there is reasonable suspicion that child abuse or abuse to a dependent adult has occurred or will occur.
3. When ordered by a court.
4. When the client provides written permission to disclose information.
5. When a worker’s compensation claim has been filed.

**Please treat all information discussed by group members as confidential and private. When attending via electronic means, please do not attend meetings from a public location or where content can be seen or heard by non-members. Thank you.**

\_\_\_\_\_  
(Print Name) (Street Address)

\_\_\_\_\_  
(City) (Zip) (Phone)

Name of Deceased: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Death: \_\_\_\_\_

Cause of Death: : \_\_\_\_\_

Relationship of patient to you:  Parent  Spouse/Partner  Child  Friend  Multiple Losses  
 Sibling  Grandparent  Other \_\_\_\_\_

Was the patient served by  Hospice of San Joaquin  Healthcare Facility  Senior Peer Counseling

Emergency contact: \_\_\_\_\_  
(Name) (Phone)

How did you learn about this supportive service? \_\_\_\_\_

Best way to contact you?  phone  email: \_\_\_\_\_

*(If you wish to be contacted by e-mail or text, please complete the reverse side of this form.)*

Would you like to be informed about future groups, workshops, events?  Yes  No

*I acknowledge the above goals and confidentiality standards, and give my consent for services:*

\_\_\_\_\_  
(Signature) (Date)

Hospice of San Joaquin Bereavement Services are offered at no charge; however, donations are gratefully accepted.



## REQUEST FOR ELECTRONIC COMMUNICATIONS

Your Name (please print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of Request: \_\_\_\_\_

I request that the following communications from Hospice of San Joaquin be delivered to me by provided electronic means. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept that risk, and I will not hold the organization responsible should such an incident occur.

METHOD	Email addresses: _____
<input type="checkbox"/> Email	_____
<input type="checkbox"/> Text	_____
<input type="checkbox"/> Zoom (teleconference)	_____

Phone Numbers: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Acknowledgement and Agreements:

I understand and agree that the requested communication is not secure, making my Protected Health Information (PHI) at risk for receipt by unauthorized individuals. I accept that risk and will not retaliate against the organization in any way should that occur.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_