



Center For Compassionate Care
of The Elizabeth Hospice

Today's Date _____

Group Registration Information

Staff Initials _____

Welcome! Thank you for choosing The Center for Compassionate Care of The Elizabeth Hospice to guide and support you through this difficult time. The personal information you provide is kept strictly confidential and is not shared with outside agencies.

***Required Fields – Please Print All Information**

*Client Name: _____ * Phone Number: (____) _____

*Address: _____

*Mailing Address (if different from above): _____

*Date of Birth: ___/___/___ Gender: Male Female

*Emergency Contact: _____ *Phone: (____) _____

If Client is a Minor (Under the age of 18)

Parent/Guardian Name: _____ Phone: (____) _____

Name of School: _____ Grade: _____

Has any Member of the child's family served in the Armed Forces? Yes No

If yes, what is the veteran's relationship to the child? _____

Reason for seeking support:

Death of loved one Serious illness of loved one Your own illness Concern for child impacted

If seeking grief support: Was your loved one cared for by The Elizabeth Hospice? Yes No

Date of Death: _____

The name of the deceased or seriously ill person: _____

Relationship to the deceased or seriously ill person: _____

How did you hear about The Elizabeth Hospice and The Center for Compassionate Care?

Family member on hospice Faith community Newspaper The Elizabeth Hospice website

Child's school Doctor recommended Flyer Other website Word of mouth

Medical Examiner's Office Other: _____

May we use your email address to send group updates, offerings and special events? Yes No

If yes: E-Mail Address: _____

(Optional Information to be used for statistical data only)

Marital Status:

Single Married Divorced Widowed

Ethnic Background:

American Indian or Alaska Native Asian Black or African American

Caucasian Hispanic or Latino Middle Eastern Native Hawaiian or other Pacific Islander

Two or more races Other _____