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_____