

## Grief Support Registration Form

Date: \_\_\_\_\_ Group: \_\_\_\_\_

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Ethnic background: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Home phone: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact name: \_\_\_\_\_

Emergency Contact number: \_\_\_\_\_

Emergency Contact relationship to you: \_\_\_\_\_

Name of loved one who died: \_\_\_\_\_

Your relationship to your loved one: \_\_\_\_\_

When your loved one died: \_\_\_\_\_

Did he/she die in a hospice program? ☐ No ☐ Yes

If yes, which hospice? \_\_\_\_\_

Briefly describe how your loved one died.

How did you hear about our services?

☐ CMH ☐ Community counselor ☐ Centrica Care Navigators  
☐ Other hospice ☐ Hospital ☐ School  
☐ Battle Creek Shopper ☐ Funeral home website ☐ Other: \_\_\_\_\_

Who are the other helping professionals with whom you are working?

I would like to receive the Centrica Grief Navigator, a monthly newsletter with updates on our upcoming support groups and grief support tips and tools. ☐ No ☐ Yes