BEREAVEMENT
PLAN OF CARE TRACKING

Patient Name: _____ Medical Record #: _____

DOD: _____

Deceased Name: _____ Relationship: _____

Phone Number: _____ Work Number: _____

IDG IMPRESSIONS

1. Survivor perceives he/she has an adequate support system: ☐ Yes ☐ No
2. IDG agrees support system is adequate: ☐ Yes ☐ No
3. Survivor indicates need for bereavement support: ☐ Yes ☐ No
4. IDG rates bereavement risk at: ☐ Low ☐ Moderate ☐ High
5. IDG has discussed concerns with survivor: ☐ Yes ☐ No
6. Other: _____

I. STANDARD BEREAVEMENT CARE (offered to all survivors)

Staff attend funeral/wake: ☐ No ☐ Yes Date: _____

	Due	Done
Bereavement services declined		
Bereavement card (completed within 1 week after DOD by IDG)		
Initial telephone contact		
Text sent to contact letter sent		
Bereavement assessment (within 4-6 weeks after death)		
Bereavement program introduction letter (1 month after death)		
Hospice satisfaction survey (1 month after death)		
Bereavement follow-up contacts (phone call, card, visit and/or other per Hospice's bereavement program)		
2 weeks:		
3 months:		
6 months:		
9 months:		
12 months:		
___ months:		

Hospice specific activities (newsletters, support group, memorial services, etc.)

List Activities:	Due	Done

II. ADDITIONAL BEREAVEMENT CARE (offered to moderate-high risk survivors based on assessment)

	Due	Done
Additional calls when deemed appropriate		
Visits offered		
Additional visits when deemed appropriate		
Referral(s):		

Additional information: _____

Date of Discharge: _____ Signature of Bereavement Coordinator: _____