SAMPLE BEREAVEMENT CHECKLIST

Sunnybrook PREGNANCY AND INFANT LOSS NETWORK

(This form is to be completed by the Healthcare Team)

FAMILY PROFILE

Last Name(s): _____ Parent Giving Birth's Name: _____

Partner's Name: _____N/A Siblings (names & ages): _____ N/A

Other Family Members/Support Persons: _____

Contact Phone Number(s): _____

PREGNANCY HISTORY

Pregnancy History: G ___ P___ T___ P___ A___ L___ EDD (yyyy/mm/dd): _____

Previous Obstetric History: _____

Current Pregnancy History: _____

_____

Assisted Reproductive Technology Used: Yes/No Details: _____ Multiple Birth: Yes/No _____

Delivery Notes: _____

INFANT PROFILE

Surname: _____ Given Name(s): _____ Sex: _____

Date of Birth: _____ Date of Death: _____ Gestational Age: _____

Corrected Age (weeks): _____ Birthweight (grams): _____

Weight at Time of Death (grams): _____

Inborn: Yes/No Outborn: Yes/No Where: _____ Age at Transfer (days): _____

Apgar Scores: (1) ____ (5) ____ (10) ____ (15) ____ (20) ____

Brief Infant Story (i.e. PTL, PPROM, termination, anomalies, IUFD): _____

_____

Coroner Contacted: Yes/No/Not applicable By Whom: _____

BEREAVEMENT CARE

Trillium Gift of Life Network Contacted: Yes/No Comments:_____
Statement of Live Birth Completed: Yes/No By Whom: _____
Family Aware of Responsibility for Burial/Cremation: Yes/No
If Baby is Less Than 20 Weeks Gestational Age, Family Aware of Options for Burial /Cremation: Yes/No
Funeral Arrangements Discussed: Yes/No Details: _____
Spiritual/Religious Care Discussed: Yes/No Details: _____
Bereavement Folder Provided: Yes/No
Family Agrees to Receive Bereavement Follow-up: Yes/No
Person(s) to Provide Bereavement Follow-up: _____

Family Provided Bereavement Support Contacts (i.e. PAIL Network, local support group): Yes/No
Details: _____
Healthy Babies/Healthy Children Discharge Notification Form Filled Out: Yes/No (must indicate on form that infant has died and date of death) Form Faxed (yyyy/dd/mm):_____ By Whom: _____
Information on Breastmilk Stoppage/Pumping Given: Yes/No

INTERACTIONS WITH THE BABY (briefly state experience at time of death)

STATE: YES or NO	PARENT WHO GAVE BIRTH	PARTNER N/A	SIBLINGS N/A	OTHER SUPPORT PERSONS/FAMILY MEMBERS
SAW				
TOUCHED				
HELD				
DRESSED				
BATHED				

Photos Taken: Yes/No
Now I Lay Me Down to Sleep or professional photographer available: Yes/No
Baptism/Blessing/Ceremony: Yes/No
Hand/Foot Moulds: Yes/No Hand/Foot Prints: Yes/No
Other (describe any interactions that may be helpful for bereavement follow-up): _____
_____

BEREAVEMENT MEMENTOS BOX
Taken by Family: Yes/No Stored: Yes/No

	Completed (Y/N)
'In Memory Of' card	_____
Photographs	_____
Hand/Foot Prints	_____
Hand/Foot Molds	_____
Gown/blanket/hat	_____
Tape Measure/Name bracelet	_____
Certificate/Blessing/Ceremony	_____
Lock of hair	_____
Crib card	_____

IMPORTANT CONTACTS REGARDING LOSS AND FAMILY CARE

CAREGIVERS INVOLVED (as applicable)	Notes
Physician(s):	
Nurse(s):	
Nurse Practitioner(s):	
Social Worker(s):	
Chaplain(s):	
Children's Aid Society Worker(s):	
Neonatal Follow-Up:	
High Risk Obstetrics:	
Breastfeeding Clinic:	
Milk Preparation Room:	
Referring Physician:	
Family Physician/OB/Midwife:	

Assisted Reproductive Technology Program:	
Consulted Services (i.e. Sick Kids, Cardiology, Genetics):	
Other:	

FOLLOW-UP (date, by whom, call/card)	
1 week:	6 month:
1 month:	1 year: