I, _____, would like a trained bereavement counselor to contact me following my loss: ☐ **YES** ☐ **NO** If ***no***, please sign form; providing further information is optional and is **NOT** required; if ***yes***, please provide the following information:

Who provided your care DURING your loss? *(More than one area may be selected.)*
☐ **REID OB/GYN OFFICE** ☐ **MOTHER BABY CARE CENTER** ☐ **SURGERY**
☐ **EMERGENCY DEPARTMENT** ☐ **OTHER:**_____

Who is your Physician? Primary _____ GYN _____

How will your primarily prefer contact?
☐ **PHONE** ☐ **MAIL** ☐ **IN PERSON** ☐ **EMAIL** ☐ **OTHER** _____

Primary Telephone: (____) ____ - ____ (H) (C) (W) Secondary Telephone: (____) ____ - ____ (H) (C) (W)

May we contact you by telephone? Primary: ☐ Yes ☐ No Secondary: ☐ Yes ☐ No
May we leave a telephone message? Primary: ☐ Yes ☐ No Secondary: ☐ Yes ☐ No

Mailing Address: _____
(Street) (City) (State) (Zip Code)

May we send correspondences through the mail, such as invitation to our yearly memorial service? ☐ Yes ☐ No

May we send correspondences through email? ☐ Yes ☐ No
If ***yes***, please provide preferred email: _____

I HAVE READ, OR HAVE HAD AN OPPORTUNITY TO EAD THIS CONSENT FOR CONTACT; OR IT HAS BEEN FULLY EXPLAINED TO ME. I AM SATISFIED THAT I UNDERSTAND ITS CONTENT AND SIGNIFICANCE. MY CONSENT IS GIVEN FREELY, VOLUNTARILY, AND WITHOUT RESERVATION. THIS CONSENT SHALL BE EFFECTIVE FOR A PERIOD OF ONE YEAR AND THREE MONTHS (1 ¼ years) FROM THE DATE THIS CONSENT IS SIGNED.

_____ _____
Patient's Signature (if eighteen year or older and appropriate) Date / Time

_____ _____
Witness to Signature: (Signature / Title) Date / Time

**Signature of family member (parent or guardian) is necessary if patient is under eighteen (18) years of age and not an emancipated minor or patient is unconscious, or otherwise not competent to give consent.

Patient, _____ is unable to consent because: _____

_____

Consent form was read to the patient or responsible person and consent for contact was given by:

_____ _____
Legally Responsible Person: (Signature / Relationship / Title) Date / Time

_____ _____
Witness to Signature: (Signature / Title) Date / Time

Retain the original for the chart and send/fax a copy of the Consent, one facesheet, the RTS Bereavement Checklist and related progress notes to (765) 983-3118 "MBCC, attention RTS"

Reid Health/R.O.S.E.
Richmond, IN 47374 (765) 983-3000
CONSENT FOR CONTACT FOLLOWING PERINATAL LOSS

Room:_____

PATIENT LABEL

CS4070