

# *Teens Helping Teens*

*Cope with the impact of death*



*~ Understanding ~ Support ~ Acceptance ~ Insight ~ Suggestions ~ Grief Education*

## *General Intake Information*

The following form is for a family to complete to begin the intake process for

*Teens Helping Teens*

Please mail completed forms to:

*Hospice Support Care  
Children/Teen Bereavement  
1701 Fall Hill Ave Suite 109  
Fredericksburg, VA 22401*

The *Teen Program Coordinator* will call you to schedule an intake meeting. For questions, please call (540) 361-7071.



GENERAL INTAKE INFORMATION

The following information is provided for the sole use of Hospice Support Care. All personal information is kept strictly confidential. \*Some information may be used for statistical purposes, grant funding requests, and grant reporting.

Parent/Guardian's Name(s) Last: \_\_\_\_\_ First: \_\_\_\_\_ Relationship: \_\_\_\_\_

Parent/Guardian's Name(s) Last: \_\_\_\_\_ First: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ \*City: \_\_\_\_\_ \*State: \_\_\_\_\_

Zip: \_\_\_\_\_ \*County: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Preferred number (circle one): Home / Work / Cell Best time to call: \_\_\_\_\_ AM / PM

Can we leave a message at this number: Yes / No Email address: \_\_\_\_\_

Please list the names of the child/children who will be participating in the program: (If there are more than 3 children participating in the program, please print additional forms, complete this section only and attach.)

1. \_\_\_\_\_ \*Male \_\_\_\_ \*Female \_\_\_\_

Date of Birth: \_\_\_\_\_ \*Age: \_\_\_\_\_ Grade: \_\_\_\_\_ \*Ethnicity: \_\_\_\_\_

2. \_\_\_\_\_ \*Male \_\_\_\_ \*Female \_\_\_\_

Date of Birth: \_\_\_\_\_ \*Age: \_\_\_\_\_ Grade: \_\_\_\_\_ \*Ethnicity: \_\_\_\_\_

3. \_\_\_\_\_ \*Male \_\_\_\_ \*Female \_\_\_\_

Date of Birth: \_\_\_\_\_ \*Age: \_\_\_\_\_ Grade: \_\_\_\_\_ \*Ethnicity: \_\_\_\_\_

Deceased's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Relationship to child/children participating in program: \_\_\_\_\_

Deceased's date of birth: \_\_\_/\_\_\_/\_\_\_ Date of death: \_\_\_/\_\_\_/\_\_\_ Age at death: \_\_\_\_\_

Cause of death: \_\_\_\_\_

Length of illness and/or hospitalization (if applicable): \_\_\_\_\_