

APPENDIX C—EXAMPLE OF A BEREAVEMENT CHECKLIST

FAMILY PROFILE

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): _____ Birth weight (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 N/A By Whom: _____

INTERACTIONS WITH THE BABY

Baby seen by:

Birth parent	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Partner	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Siblings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Family Members	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Baby touched by:

Birth parent	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Partner	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Siblings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Family Members	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Baby held by:

Birth parent	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Partner	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Siblings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Family Members	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Baby dressed by: Birth parent Yes No
Partner Yes No
Siblings Yes No
Family Members Yes No

Baby bathed by: Birth parent Yes No
Partner Yes No
Sibling Yes No
Family Members Yes No

Photos Taken: Yes No
Baptism/Naming ceremony/Blessing: 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 MEMENTOES BOX

'In Memory Of' card: Yes No
Photograph: Yes No
Lock of hair: Yes No
Hand/Foot Moulds: Yes No
Hand/Foot Prints: Yes No
Clothing
(e.g. gown, blanket, hat, booties): Yes No
Tape Measure: Yes No
ID Band: Yes No
Sympathy card: Yes No
Certificate/Blessing/Ceremony: Yes No

Bereavement Box:

Taken by family: Yes No
Stored: Yes No

VOLUNTEER PHOTOGRAPHER

Referral made: Yes No Date: _____ By whom: _____
Consent Obtained: Yes No By whom: _____
Photos taken (yyyy/mm/dd): _____

BEREAVEMENT CARE

Organ and tissue donation agency contacted: Yes No

Comments: _____

Statement of live birth completed: Yes No

By Whom: _____

Family aware of responsibility for burial/cremation: Yes No

If the baby is less than 20 weeks gestational age, is the 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 with bereavement support contacts: Yes No Details: _____

IMPORTANT CONTACTS REGARDING LOSS AND FAMILY CARE

Caregivers involved (as applicable)	Name(s)
Staff physician(s)	
Nurses(s)	
Nurse practitioner(s)	
Social worker(s)	
Psychologist	
Chaplain(s)	
Children's Aid Society worker(s)	
Neonatal follow-up	
High-risk obstetrics	
Breastfeeding clinic	
Referring physician	
Family physician/OB/Midwife	
Assisted Reproductive Technology program	
Other:	

FOLLOW-UP

1 Week (yyyy/mm/dd):	By whom:	Call Card
1 month (yyyy/mm/dd):	By whom:	Call Card
6 month (yyyy/mm/dd):	By whom:	Call Card
1 year (yyyy/mm/dd):	By whom:	Call Card