PALLIATIVE CARE BUFFALO
Wilson Support Center

TITLE OF GROUP: AFTER A PARENT DIES SUPPORT GROUP

NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DOB: _____ AGE: _____ PHONE: _____

NAME OF DECEASED: _____DATE OF DEATH_____

CAUSE OF DEATH: _____

HAVE YOU EXPERIENCED ANY OTHER LOSSES IN THE PAST YEAR {i.e.: divorce, loss of job, relocation, deaths, serious illness, serious financial problems}?
Yes____No_____

Please explain: _____

_____

_____

_____

ARE YOU RECEIVING INDIVIDUAL COUNSELING AT PRESENT? Yes____No_____
If yes, please indicate the name of the agency or the counselor:

_____

HAVE YOU ATTENDED OTHER GROUPS AT WSC? Yes____ No____
When?_____

HOW DID YOU HEAR OF THE GROUP? _____

_____