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| Parent's Name(s): | Phone Number: |
| Address:  | |
| Baby's Name: | <input type="checkbox"/> Male <input type="checkbox"/> Female Weight |
| Date & Time of Birth: | Gestational age: Age (days, hrs, min) |
| Date & Time of Death: | Other Children (Name, age) |
| Type of loss: <input type="checkbox"/> Fetal loss <20 weeks <input type="checkbox"/> SB antepartum <input type="checkbox"/> SB intrapartum <input type="checkbox"/> Neonatal Death | |
| History of previous losses: _____ | |

| DATE | CHECK TO INDICATE COMPLETION | INITIAL |
|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| | Baby seen: <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> grandparents <input type="checkbox"/> other (specify) _____ <input type="checkbox"/> declined Baby touched: <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> grandparents <input type="checkbox"/> other (specify) _____ <input type="checkbox"/> declined Baby held: <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> grandparents <input type="checkbox"/> other (specify) _____ <input type="checkbox"/> declined Comments: _____ | |
| | Notification of Death Physician(s) Specify: _____ <input type="checkbox"/> Admitting <input type="checkbox"/> Medical | |
| | Support Services Social worker: <input type="checkbox"/> Notified <input type="checkbox"/> Visited: name _____ Clergy: <input type="checkbox"/> Notified <input type="checkbox"/> Visited: name _____ <input type="checkbox"/> Naming ceremony <input type="checkbox"/> Baptism Parent support group: <input type="checkbox"/> Notified <input type="checkbox"/> Visited: name _____ Genetics Counsellor: <input type="checkbox"/> Notified <input type="checkbox"/> Visited: name _____ <input type="checkbox"/> Genetic testing requested and explained to parents. Other: (specify) _____ | |
| | Memory and Keepsakes <input type="checkbox"/> Photographs, pictures taken by _____ <input type="checkbox"/> given to parents <input type="checkbox"/> on file <input type="checkbox"/> Identification bracelet <input type="checkbox"/> given to parents <input type="checkbox"/> on file <input type="checkbox"/> Foot and handprints (both hands and feet) <input type="checkbox"/> given to parents <input type="checkbox"/> on file <input type="checkbox"/> Lock of hair <input type="checkbox"/> given to parents <input type="checkbox"/> on file <input type="checkbox"/> Crib Card <input type="checkbox"/> given to parents <input type="checkbox"/> on file <input type="checkbox"/> Tape Measure <input type="checkbox"/> given to parents <input type="checkbox"/> on file <input type="checkbox"/> Clothes <input type="checkbox"/> Blanket/Quilt <input type="checkbox"/> given to parents <input type="checkbox"/> on file <input type="checkbox"/> Other _____ <input type="checkbox"/> Indicate location of file: _____ | |
| | Funeral and Burial Arrangements <input type="checkbox"/> Options given to parents <input type="checkbox"/> Funeral Home contacted: Date _____ Time _____ <input type="checkbox"/> Service arranged in hospital Name of Funeral Home _____ <input type="checkbox"/> Service out of hospital <input type="checkbox"/> Hospital Burial <input type="checkbox"/> Mother able to attend <input type="checkbox"/> Other: (specify) _____ | |
| | Forms (as applicable for stillbirth or neonatal death) <input type="checkbox"/> Notice of Birth or Stillbirth <input type="checkbox"/> Autopsy Consent <input type="checkbox"/> Registration of Stillbirth REG 3218 <input type="checkbox"/> Clinical Photography request <input type="checkbox"/> Registration of Birth REG3216 <input type="checkbox"/> Burial Permit REG 3247 <input type="checkbox"/> Medical Certificate of Stillbirth REG 3219/Death REG 3122 <input type="checkbox"/> Alberta Study of Perinatal and Neonatal Deaths <input type="checkbox"/> Registration of Death REG 3260 <input type="checkbox"/> Other: (specify) _____ | |
| | Follow-up <input type="checkbox"/> Physician Appointment: _____ <input type="checkbox"/> Social Worker - Name _____ <input type="checkbox"/> Support Group <input type="checkbox"/> Public Health notified - Name _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Discharge Information provided | |
| | Special requests by parents: _____ | |
| INITIAL | SIGNATURE | INITIAL |
| | | |