Bridging the Gap
A Hospice Program for Grieving Children
Sponsored by Peterson Hospice
An outreach of Peterson Regional Medical Center

Parent Fact Sheet for Fall 2013 - Spring 2014

Who: Children grade K-12
What: Bridging the Gap: a program for grieving children and their families
When: 10-8, 10-22, 11-5, 11-19, 12-3, 12-17, 1-7, 1-21, 2-4, 2-18
Where: First Presbyterian Church, 800 Jefferson, Kerrville
Time: 6:00 (light supper) sessions from 6:30 until 8 PM
Sponsored by: Peterson Hospice (there is no charge for program)

The purpose of the Bridging the Gap program is to provide a unique support group for children who have experienced loss through the death of someone significant in their lives. During this program, children in grades K - 12 will be given the opportunity to (1) recognize and express their feelings, (2) build self-esteem through validation, (3) receive guidance as they adapt to the changes in their families, and (4) develop skills in dealing with loss that they may utilize throughout life.

Running concurrently with each group of the children's sessions is a parent's group created uniquely for them. This group is designed to help parents have a better understanding of the changes going on with their children.

Referrals to this program may be made through school counselors, ministers, or by simply calling Peterson Hospice at 258-7799 or email Jennifer Latiolais at jlatiolais@petersonrmc.com.

Prior to enrolling families must submit registration materials and attend an orientation with the children's bereavement coordinator.

There are a limited number of spaces available, so we recommend you sign up as soon as possible. Please keep this parent fact sheet for your future reference.
Bridging the Gap
Intake Questionnaire: The Family

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Intake Questionnaire: Family Information

Date _______________

General Information

Name(s) of parent(s) or guardian(s):
______________________________________________________
______________________________________________________

Address: ________________________________
_________________________________________________
City: ___________________ Zip: __________

Phones:
home: ________________ work: ________________

Cell: ________________ Do you text?____
E-mail: ________________________________

CHILDREN: (PLACE A CHECK BY THOSE WHO WILL PARTICIPATE IN OUR GROUPS)
(PLEASE LIST FULL NAME) (BIRTH DATE)

☐ ______________________________ M F ________
☐ ______________________________ M F ________
☐ ______________________________ M F ________
☐ ______________________________ M F ________

Family’s religious preference: ________________________________
Are there any special beliefs that we should know about? _________
_________________________________________________________________
About the Deceased

Name: _____________________________________________________

Relationship to children (e.g.: father, mother, sister, brother, grandfather, grandmother, aunt, uncle, friend, etc.): ________________________________

Birth date (if known): __________
Death date: __________ Age: ______

Cause of death: ________________________________________________

Death was: □ sudden □ lingering □ other

Have the children been told everything about the death? □ Yes □ No
If not, please explain: ___________________________________________
________________________________________________________________

What kind of funeral & burial were chosen? _________________________
________________________________________________________________

Did the children attend? □ Yes □ No
If not, why not? _________________________________________________
________________________________________________________________

Has anyone else close to the children died? □ Yes □ No
If yes:
Name: _________________________________________________________

Relationship to children: _________________________________________

Birth date: __________ Death date: __________ Age: __________

Cause of death: _________________________________________________

Death was: □ sudden □ lingering □ other

Use back side for multiple deaths

Have there been any other significant losses (divorce, moving, pet loss, etc.)?
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

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For Homicide Survivors Only:

THE FOLLOWING INFORMATION WILL BE KEPT IN STRICTEST CONFIDENCE.

Name of suspect or defendant: _____________________________________  □ Unknown

County where offense occurred: ______________________________________

Date of offense: ______________

What has happened so far? ______________________________________
________________________________________________________________
________________________________________________________________

What other programs or therapy have you tried?

(Please check all that apply)

☐ School counselor  ☐ Pastoral counselor
☐ Private counselor  ☐ Other program(s):
☐ Psychiatrist
☐ Psychologist

Who recommended that you come to Bridging The Gap?

(Please check all that apply)

☐ Therapist or counselor  ☐ Friend or acquaintance
☐ Teacher  ☐ Media
☐ Doctor, nurse or other medical professional  ☐ Other:
☐ Clergy

Please give us any other information that will help us work with your children:
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
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Intake Questionnaire: About Your Child

PLEASE FILL OUT A SEPARATE FORM FOR EACH CHILD!

Date _______________

Child’s Name:_____________________________ Nickname:_____________________________

Age:_________ Birthdate:_________ School Grade:_____________________________

School attending:_________________________________________________________________

Child’s cell:_____________________________ Does he/she text?________________________

Child’s Email:_____________________________________________________________________

T-shirt size: Adult: XL Lg Med Sm Youth: Lg Med Sm

Please describe this child’s mental/emotional state:
________________________________________________________________________________

How attached was this child to the deceased?
Extremely More than normal Normally attached Less than normal Hardly attached at all
☐ ☐ ☐ ☐ ☐

How well has this child been able to express feelings?
Completely Well Average Not so well Not at all
☐ ☐ ☐ ☐ ☐

Is this child seeing a counselor? ☐ Yes ☐ No
If so, whom? ________________________________________________________________

Is this child on medication? ☐ Yes ☐ No
If so, what? ________________________________________________________________