Grief Support Referral Form

The Michigan Department of Health and Human Services (MDHHS) is dedicated to supporting families after miscarriage, stillbirth, and infant death. Through contracted services, we provide written materials, phone support, and connection with community resources and support groups. All services are free.

Date: _____

Mother's Name: _____

Father's Name: _____

Address: _____

Apt/ Unit: _____

City: _____ Zip Code: _____

County: _____

Email: _____

Cell Phone: _____

Home Phone: _____

Number of other children: _____

Number of previous losses: _____

Primary Spoken Language: _____

Additional Information: _____

_____

_____

_____

Infant's Name: _____

Sex: ___Male ___Female

Race: _____

Ethnicity: _____

Gestation: _____

Date of Birth: _____

Date of Death: _____

Cause of Death: _____

Hospital Where Born: _____

REFERRAL SOURCE

Name: _____

Title: _____

Organization/Agency: _____

_____

Phone: _____

Email: _____

CONSENT AND CONFIDENTIALITY

Completion and submission of this form indicates that the above individuals accept this referral for grief services. The information received is only shared with local health departments and organizations who offer grief support services.

CONTACT

Initial referrals are handled by Dr. John Canine at Maximum Living, Inc. **Please fax this completed form to 248-814-0710. You can also call 248-814-0706.**

For questions about bereavement and grief services through MDHHS, contact the Infant Health Unit at 517-335-8955.