



Please check appropriate box(es):

Support Group Participant

Connections Participant

### Heartstrings Participant Information Form

All information on this form will remain strictly confidential.

Date \_\_\_\_\_ Referral Source \_\_\_\_\_

Family Information:

Your Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_

Email \_\_\_\_\_

Occupation/Employer \_\_\_\_\_

Marital Status (Please circle) Married      Single

Spouse/Partner's Name \_\_\_\_\_ Age \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_

Email \_\_\_\_\_

Occupation/Employer \_\_\_\_\_

Religious denomination (if applicable)      Self \_\_\_\_\_ Spouse/Partner \_\_\_\_\_

Language(s) spoken other than English      Self \_\_\_\_\_ Spouse/Partner \_\_\_\_\_

Please complete the following questions about the loss of your baby. (You may use the back of this page if you need more room or have had more than one loss.)

1. What date did the death of your baby occur? \_\_\_\_\_
2. Did the death occur     during the pregnancy? How far along in the pregnancy were you? \_\_\_\_\_  
 at birth? How far along in the pregnancy were you? \_\_\_\_\_  
 after birth? How old was your baby? \_\_\_\_\_
3. Did your baby spend any time in the neonatal intensive care unit?     Yes     No
4. What was the cause of death? \_\_\_\_\_
5. What is your baby's name? (if applicable) \_\_\_\_\_

Names of living children (if applicable)	Date of birth	Sex
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Please complete additional questions on the back of this page.)

Would you prefer we contact you at  home?  work?  by email?

May we leave messages on your answering machine?  Yes  No

Support Group Participants Only:

Will both you and your spouse/partner be attending the group?  Yes  No

Connections Applicants Only:

Would you like a support parent for  yourself only?  both you and your spouse/partner?

Please use the space below to share any other information you would like your support parent to know in order to better support you.

---

---

---

Release of information

I give my(our) permission to release my(our) names, telephone number and other relevant information to another parent for a Connections match.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Remarks (to be completed by executive director or program coordinator)

Date

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Matched to \_\_\_\_\_ Date \_\_\_\_\_

Please call 336-335-9931 if you have any questions. Mail the completed application to:  
Heartstrings, PO Box 10825, Greensboro, NC 27404-0825