# Hospice of the Carolina Foothills, Inc.

# BEREAVEMENT CONTACT

Patient: _____ ID#_____

Person Contacted_____ Date of Contact_____

Type of Contact: Phone Call_____ Contact by mail_____

Visit_____ Funeral/Visitation____ Time In_____ Time Out_____

Total Time_____ Mileage_____

Summary of Contact:

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Signature_____ Title_____

For Office use only: Reviewed by _____ Date_____

Ber/Contact/0603