FRANKLIN COUNTY FETAL-INFANT MORTALITY REVIEW (FIMR)

FAMILY VISIT CONSENT FORM

Purpose of the Visit: The purpose of this visit is to offer information, counseling, and other supportive services to you and your family. If you agree to participate, a program coordinator from Columbus Public Health will meet you at a time and place that's convenient and private, or speak over the phone. Many visits happen in the client's home and take about an hour.

Your Story: Talking about the death of one's child is different for every person. Some parents find talking about their baby hard, others find that it brings them comfort. In either case, the information you share may help other families from losing a baby in the future. The interviewer is not a professional counselor but, if needed, will connect you with grief supports to help you cope with your feelings.

Choice: Talking with the program coordinator is completely voluntary and you may skip any question at any time. You are also free to stop the visit at any time. You will not be paid for participating in the visit.

Confidentiality: All information that identifies you, your family, or your health care providers will be kept private. All CPH staff and team members have signed a confidentiality agreement outlining how they will maintain your privacy. Information shared about possible child abuse/neglect or harm to self or others will be reported as required by law. Therefore, confidentiality will be protected to the full extent permitted by law.

Questions: If you have any questions concerning the interview or the FIMR Program, please contact Andrea N. Jarvis-Galvin, BA, ATS at Columbus Public Health at 614-645-6537 or at anjarvis-galvin@columbus.gov.

_____ **By initialing here, I affirm that I have been given the Columbus Public Health Notice of Privacy Practices.**

Consent: I have read this form and understand the purpose of this visit with the Fetal Infant Mortality Review Program staff. I hereby give my consent to this visit. I understand that all information obtained from this visit will be kept strictly confidential, and that neither my name nor the name of anyone else in my family will appear in any publications or reports. However, if I request connection with community resources, I hereby give consent for my contact information to be shared with those resources for my benefit.

Client Signature: _____

Client Name (printed): _____ Date: _____

Interviewer Signature: _____

Interviewer Name (printed): _____ Date: _____

If client is under 18,

Client's Parent/Guardian Signature: _____

Parent/Guardian Name (printed): _____ Date: _____

Client Name (printed) refuses to sign receipt of the Privacy Notice: _____

Staff Member Signature: _____Date: _____

Adapted from: Cincinnati Health Department FIMR *chp12/13/18*