HOSPICE / RESIDENTIAL CARE
DEATH REPORT FORM
COUNTY CORONER

, Coroner
Fax:

Name Program: _____ **Representative:** _____

Present at Scene? YES NO Time Notified: _____ **Date Patient Entered Hospice** _____

Patient's Name _____

Address: _____

City: _____**State:** _____ **Zip Code:** _____

Date of Birth: _____ **Age:** _____**Social Security Number:** _____

Terminal Illness: _____

Treatment : _____

Name of physician who will sign death certificate: _____

Did patient appear clean and well cared for? YES NO Is patient free of trauma? YES NO

Actual Time of Death: _____ **Consistent with last time seen alive? YES NO**

Any evidence of injury, accidents, or falls? YES NO

Any recent fractures? YES NO There Extent? _____

How and when they were sustained? _____

Medications in order? YES NO Method medication disposed of? _____

Disposed of by: _____ **Witnessed by?** _____

Any evidence to suggest anyone hastened the death? YES NO

Anything suspicious about patient's death? YES NO

Funeral Home body released? _____

Statement: _____

_____

_____

Investigator: _____ **Title:** _____