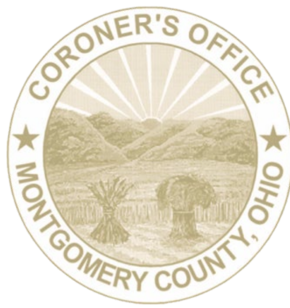

NURSING FACILITY DEATH REPORT FORM

PLEASE PRINT

Facility Name____ Phone__________________________

Facility Address ____

Person Reporting____________________________________ Title________ Date / Time____________________

Decedent's Name____ Age _____DOB_________
(First) (Middle Int.) (Last) (Suffix)

Sex________ Race___________ Marital Status_______________ SSN____________-_______-___________

Decedent's Home Address____
(Street) (City) (Zip)

Date admitted ______________________________ Medical HX_____________________________________

____

*History of past injury / trauma ____________

Describe____

Signing Physician____

Date Pronounced________________ Time Pronounced___________ By______________________________
(LPN Can NOT pronounce death)

EMS Called________ Resuscitation Attempt_______ Describe______________________________________

Time Last Contact_______________ By____

Next of Kin____Relationship______________________

Address____ Phone____________________

Nurse____ Title______________________________

Note: This form must be faxed or emailed to the Coroner's Office ASAP. If any of the following conditions apply, <u>you must immediately</u> call the investigator on duty...any death as the result of trauma or any patient who was admitted to your facility due to past injury, any death following an invasive procedure, admitted less than 24 hours prior to death, and any suspicious or unexpected death and any death regardless of circumstances involving a MRDD patient.

Phone: 937-225-4156 Email coronerrecords@mcohio.org Fax: 937-228-6703

(Rev. 7/2022)