

DEATH INVESTIGATION WORKSHEET

(A) CALL INFORMATION			CASE No:		
Day:	Date:	Time Notified:	Time On Scene:	Other No:	
Notified by:		Response: <input type="checkbox"/> Scene <input type="checkbox"/> Notification Location:	Death Type: <input type="checkbox"/> Home Death <input type="checkbox"/> MVC <input type="checkbox"/> Cremation Only <input type="checkbox"/> Referral <input type="checkbox"/> Scene Death <input type="checkbox"/> ER <input type="checkbox"/> Other: _____		
(B) DECEDENT INFORMATION					
Deceased:			Phone:		
Race:	Sex:	DOB:	Age:	Marital Status:	
Social Security Number:					
Address:		City:	State:	ZIP:	
Occupation:	Employer:		Identified by:		
(C) NEXT OF KIN INFORMATION					
Next of Kin:			Relationship:		
Kin Address:		City:	State:	Zip:	
Kin Phone			Date Notified:		
Time Notified:	Notified by:		Agency:		
(D) DEATH DEMOGRAPHICS					
Place of Onset			City/Village/Town:		
Place of Death:			City/Village/Town:		
County of Onset:			County of Death:		
Date Body Found:	Time:	Found By:			
Pronounced by:	Time:	Date:			
Last Seen Alive Time?:	By Whom?	Where?:			
(E) MEDICAL/SOCIAL HISTORY					
PCP:	Clinic/Hospital:		Last Visit:		
Med Hx:			Source:		
Rx Meds:(attach Rx Sheet if necessary)					
Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No Contribute to Death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Substance Abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
(F) INJURY INFORMATION <i>(use death detail worksheet)</i>					
Date:	Time:	County:			
Place of Injury:	Address:	C/V/T:			
List Injury(s)		How?			
(G) TRANSPORT/DISPOSITION/FUNERAL HOME					
Decedent Transported by:		Date/Time:			
Transported To:		Release Authorized <input type="checkbox"/> Yes <input type="checkbox"/> No			
Funeral Home Released to:		Date Released:			
City:	Expected Disposition of Remains:	Requestor:			
(H) OTHER AGENCIES					
Law Enforcement:	EMS:	Fire:			
Personnel Present:		Agency Case No:			

(I) DEATH CERTIFICATE

ME Name: MD Name:

(J) EXPECTED DISPOSITION:

Cremation: Embalming: Donation: Disinterment: Cremation Permit Issued?

(K) SUPPLEMENTAL INFORMATION N/A

Eye Donation: Tissue/Organ Donation Supplemental Report Photos Supp Photos
Personal Property Form Death Detail Worksheet: Body Exam Checklist Med Records Request
Toxicology Request: Violent Injury: Rx Medications: Child Fatality: Any death < 18yrs
OSHA: Evidence Form: SIDS/SUIDI Check List All deaths < 1 yr **NOTES:**

(M) DONATION MTF REFERRAL HOTLINE 866-818-9005

CONSENT REGISTRY/DOT FILE CHECKED Yes No Death reported? Yes No

If No: Reason: LSA: Automatic Rule Out Family Declined Consent:

(N) CHAIN OF CUSTODY REQUIRED: Yes No

Body Bag Sealed by: Time Sealed: Tag Number:

(O) TOXICOLOGY/DRUGS/ALCOHOL SCREEN FOR THIS CASE? Yes No

Lab:

(P) AUTOPSY:

Autopsy: Yes No Ordered by: Certification Only: X-rays:

Pathologist Name: Date:

(Q) PRELIMINARY CAUSE AND MANNER

1. Natural: Suicide: Accidental: Homicide: Pending:

2. Contributing Factors:

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