

[ ]  Home [ ]  Pathways Hospice Care Center

[ ]  Independent Living Facility [ ]  Assisted Living or Skilled Nursing Facility

NAME OF DECEDENT:       FUNERAL HOME:

FACILITY NAME & ADDRESS or HOME ADDRESS:

CITY:       ZIP CODE:

DATE OF BIRTH:       AGE:       MALE: [ ]  FEMALE:[ ]

DATE OF DEATH:       TIME OF DEATH:

DATE PRONOUNCED:       TIME PRONOUNCED:

PRONOUNCED (IN PERSON) BY (MD, DO, RN, LPN, EMT-P):

NEXT OF KIN:       RELATIONSHIP:       CONTACT PH #:

MEDICAL HX / PRIMARY DX:

PRIMARY PHYSICIAN:       Phone#:       Fax#:

DNR? [ ] YES [ ]  NO

HOSPICE? [ ] YES [ ]  NO (If Yes, which Hospice Agency?       ADMIT DATE TO HOSPICE:

*Please check answers to questions below:*

Was this a Medical Aid in Dying? [ ] NO [ ]  YES

Any recent injuries or falls with injury? [ ]  NO [ ]  YES Any recent surgeries? [ ]  NO [ ]  YES

Any recent violence or physical altercations? [ ]  NO [ ]  YES Suspicion of overdose? [ ]  NO [ ]  YES

Equipment malfunction? [ ]  NO [ ]  YES Other unexpected events? [ ]  NO [ ]  YES

REPORTING PARTY (Person filling out Form):       TITLE:

If YES was answered to any of the above, please have Coroner Investigator paged immediately, day or night, at: 970-498-6161

If NO was answered to all of the above, FAX FORM TO CORONER’S OFFICE WITHIN 12 HOURS OF DEATH: 970-498-6170

Or EMAIL FORM To: larimercoroner@larimer.org