

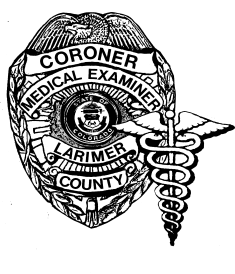
Home  Pathways Hospice Care Center

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