

**DOUGLAS COUNTY CORONER
IN-HOME HOSPICE PROGRAM DEATH REPORT**

Decedent's Full Name: _____ Birthdate: _____

Date of Death: _____ Place of Death: _____
Street Address City

Time Death Pronounced: _____ By Whom: _____
(must be a medical professional, coroner representative or funeral home personnel)

Person(s) Witnessing Death or Finding Decedent: _____

Location of Decedent at Death: [] in bed [] not in bed. If location at time of death is other than bed, then describe where the decedent was found and the position of the decedent's body:

IF THE CIRCUMSTANCES INVOLVING THE LOCATION OF THE BODY, THE REPORT OF THE DEATH, OR THE SCENE IN THE HOME ARE SUSPICIOUS OR IF ANY EVIDENCE OF STRUGGLE, TRAUMA, ACCIDENTAL DEATH OR UNNATURAL CAUSATION EXISTS, THEN IMMEDIATELY CALL 911 TO REPORT THE DEATH AND DISPATCH LAW ENFORCEMENT TO THE HOME.

Checklist for responding Medical Personnel/Funeral Director. (If each of the following cannot be answered "Agree," call 911 immediately to report the death.)

| | <u>Agree</u> | <u>Disagree</u> |
|--|--------------|-----------------|
| 1. Decedent Appeared Well Cared For: | [] | [] |
| 2. No Suspicions of Trauma or Unnatural Death: | [] | [] |
| 3. No Suspicious Findings at Funeral Home During Preparation of the Body: | [] | [] |

Hospice Program: _____ **Nurse:** _____ **Physician:** _____

Primary Illness(es) Requiring Hospice: _____

All persons completing any portion of this form must sign below.

Signature Title Date

Signature Title Date