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.)

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

In-Home Hospice Program Death Report (DCPA/C 12/21/05)