HOSPITAL or HOSPICE
PATIENT REVIEW INFORMATION
FOR
DETERMINATION OF MEDICAL EXAMINER JURISDICTION

PART 1

The following information is important for determining Medical Examiner Jurisdiction upon the death of a patient.
ALL questions in this section must be answered.

1) Was the patient's life style significantly changed due to trauma? _____ Yes _____ No
(Example: The patient was active prior to the fracture of their hip. Since the fracture they have been bedridden)

2) Do you feel trauma caused or contributed to the death? _____ Yes _____ No

3) Does the patient's condition involve any of the following:

A) Criminal Violence _____ Yes _____ No **B**) Suicide _____ Yes _____ No

C) Work related Illness or Trauma _____ Yes _____ No **D**) Old Trauma _____ Yes _____ No

If any of the above questions was answered "yes", then the remainder of this form must be completed. Upon completion,
contact the Medical Examiner Investigator at (561) 688-4575.
(A Forensic Investigator is available to answer any questions 24 hours a day, seven days a week)

_______________________________________ _______________________________________

Attending Physician Printed Name **Attending Physician Signature**

PART 2

Patient Information

Name of patient: ____ Age _______
DOB_____/______/_________

Next of kin: _______________________________________ Relationship to deceased ______________________

NOK address: ________________________________ City____________________ State_________
Zip____________

Home Telephone _______________________________ Business Telephone _________________________

Date and time of admission to Hospice ______/__________/_________ ________________am / pm

Transferred from: ____

****A copy of the Hospital and/or Hospice chart, along with a copy of the primary care facility chart (if available) must accompany the deceased to the Medical Examiner's Office.****

Medical Examiner Case Information

Required Information

Part 3
Injury Information

1) Where did injury occur?

____
Exact location and address (Example: Driveway, 2260 48th Dr. No. Delray Beach, Fl. 33466)

2) How did injury occur? (I.e.: tripped, fell, pushed, vehicle collision)
____

3) Injuries received:
____

____

____.

4) When did injury occur? ________/__________/______________ Date
Time _______________________________am/pm

__ALL MEDICAL RECORDS AND THIS FORM MUST ACCOMPANY THE BODY TO THE MEDICAL EXAMINER OFFICE__

Date and time Medical Examiner Investigator was contacted: ______/________/________ _____________am / pm

Name of Investigator Contacted: ____

Medical Examiner's Office
District 15
3126 Gun Club Road
West Palm Beach, Florida 33406
Telephone: 561-688-4575
Fax: 561-688-4592