Please fax this form to the Coroner or Medical Examiner for the county of the expected death.

FAX NUMBER: **(507) 266-6658** DATE: / / OFFICE: **Midwest Medical Examiner's Office**

HOSPICE PRE-REGISTRATION FORM

This is a permanent record so accuracy and legibility are essential

NAME [Last]_____ [First, full, legal] _____ [Middle] _____

ADDRESS [Street] _____ [Apt] _____ [City] _____ [County] _____ [State] ___ [Zip] -

PHONE ( ) - DATE OF BIRTH / / SEX [M/F] RACE _____

MARITAL STATUS (CHECK ONE) ☐ Married ☐ Widowed ☐ Divorced ☐ Never been married

Please check all that apply: ☐ No Living Parents ☐ No Living Children ☐ No Living Siblings

LEGAL NEXT-OF-KIN (if you are not sure of who this is, see MN Statute **149A.80 subdivision 2)**

NAME [Last] _____ [First] _____ RELATIONSHIP _____ PHONE ( ) -

ADDRESS [Street] _____ [Apt] _____ [City] _____ [State] ____ [Zip] -

OR AUTHORIZED HEALTH CARE AGENT
Fax a copy of Health Care Agent Authorization with this form.

NAME [Last] _____ [First] _____ RELATIONSHIP _____ PHONE ( ) -

ADDRESS [Street] _____ [Apt] _____ [City]_____ [State] ___ [Zip] -

ATTENDING PHYSICIAN (must be the physician who will sign the death certificate)
[Full Name of Physician] _____

PHYSICIAN'S PHONE ( ) - DATE LAST SEEN / / (*Must be within 180 days)

DIAGNOSIS THAT IS EXPECTED TO CAUSE DEATH: _____

ANY FALLS/INJURY RESULTING IN LONG BONE FRACTURES OR NEUROLOGICAL CHANGE IN THE PAST SIX MONTHS?
Describe and include dates:

ANY HISTORY OF FALLS OR TRAUMA? _____ If YES, CONTACT MEDICAL EXAMINER/CORONER FOR FURTHER INSTRUCTION.

Funeral Home _____ (phone number of funeral home MUST be supplied at time of death)
IF THE PATIENT IS INTERESTED IN WHOLE BODY DONATION, PLEASE CALL U of M 612-625-1111 or Mayo 507-284-2693

IS THE PATIENT INTERESTED IN EYE OR TISSUE DONATION? ☐Yes ☐No If yes, call 1-800-247-4273 or 1-877-365-3668

REGISTERING HOSPICE AGENCY _____ **LIC #** _____***MUST BE A LICENSED HOSPICE AGENCY**

REGISTERED BY: [Last] _____ [First] _____PHONE ( ) - FAX ( ) -

This form will be retained in the coroner's or medical examiner's office and the registration will be in effect for 180 days from the date of complete pre-registration. At that time a **new form must be submitted by the registering agency.*

FOR CORONER/MEDICAL EXAMINER OFFICE USE ONLY:
Date Received _____ Accepted by_____