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

FAX NUMBER: (**651**) 266 - **1730** DATE:  /  /  COUNTY:

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

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_