COUNTIES: **Hennepin, Dakota, and Scott** FAX NUMBER: **(612) 321-3556**

HOSPICE PRE-REGISTRATION FORM

**** Please type or print legibly ****

NAME _____
[Last] [First] [Middle]

ADDRESS _____
[Street] [Apt] [City] [Zip] ***[COUNTY]***

PHONE ( ) - DATE OF BIRTH _____ SEX _____ RACE _____

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

Check all that apply: ☐ No Living Parents ☐ No Living Children ☐ No Living Siblings ☐ No Blood Relatives

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LEGAL NEXT-OF-KIN **OR** AUTHORIZED HEALTH CARE AGENT *(must forward **Health Care Directive** with this form)*
[refer to MN Statute 149A.80 subdivision 2 if unsure who is next of kin]

NAME _____ RELATIONSHIP _____
[Last] [First] [Middle]

ADDRESS _____Phone number_____
[Street] [City] [State] [Zip]

Does this patient have a medical history of TBI, paralysis, overdose, etc? Describe and include dates *(attach medical records)*

In the past six months, has there been trauma or fracture(s)? *(attach medical records)*

I have **verified** with the certifying physician that the death record will be completed as follows:

Expected Cause of Death: _____

Any other diagnoses that may contribute to death? _____

CERTIFYING PHYSICIAN (full name) _____

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

IS THE PATIENT INTERESTED IN EYE OR TISSUE DONATION? ☐Yes ☐No A donation referral will be made if yes/left unanswered

REGISTERING HOSPICE AGENCY: _____ LIC # _____ [MUST BE LICENSED AGENCY]

REGISTERED BY: _____ PHONE _____ FAX _____
[Last] [First]

*This form will be retained in the coroner's / medical examiner's office and the registration will be in effect for **180 days from the date last seen by the physician**. At that time, **a new form** must be submitted by the registering agency.*

FOR CORONER/MEDICAL EXAMINER OFFICE USE ONLY: Date Received_____Accepted by_____