

Demographics	HCF Chart #	Last Name:		First Name:	
	Demographics	Sex: Male / Female		Religion:	
	Date of Birth (mm / dd / yyyy)	____ / ____ / _____		Race:	
	Next of Kin (NOK)	Last Name:		First Name:	
	NOK Relationship				
	NOK Contact Information	Tel: () -		Cell: () -	
	Was NOK Notified?	Yes / No		If No, # attempts made:	
	If NOK is unknown was NYPD notified?	Yes / No	Last Name:	Shield# Pct #	
	If NOK is unknown was PA notified?	Yes / No	Last Name:	Tel: () -	
	Please check one of the burial wishes below as identified by the NOK:				
City Burial requested <i>(signed authorization must be attached)</i>		Private Burial requested		Unknown	
Family requests additional time	Reason:				
Objection to Autopsy?	Yes / No		If Yes, reason:		
Hospital Data	Hospital / Medical Center Name				
	Admission Type (Check one)	ER	Inpatient	Long Term Care	
	Transported to Hospital (Check one)	by Self or Family		by EMS Unit	
	Admission Date	____ / ____ / _____		Time:	
	Address from where decedent was transported:				
	Primary Medical Doctor (PMD)				
	PMD Contact Info	Tel: () -		Cell: () -	
	Pronouncing Physician Name			Tel: () -	
	Date Death Pronounced	____ / ____ / _____		Time:	
	Suspected Cause of Death				
	Required documents must be attached:	Face Sheet	EMS Patient Report (PCR)	Discharge Summary or H&P	
		Death Certificate	Burial Permit	Authorization for City Burial <i>(If requested)</i>	
Clinical Summary	Please summarize the circumstances and reasons for admissions, past medical history, diagnostic work, surgical procedures and findings. Please report any bullets, alterations of wounds and toxicology studies.				

Prepared by _____

Signature _____

Date _____

Title _____

Department _____

Contact # _____