



ME Clinical Summary Worksheet

Version 3.0 Instructions

October 2019

<p>OCME Clinical Summary Worksheet Fax to OCME Communications 24/7 at (844) 500-5762</p> <p>Please indicate why the health care facility (HCF) is submitting the Clinical Summary Worksheet to OCME Communications. Please check only one of the following options:</p> <p><input type="checkbox"/> OCME has accepted jurisdiction of this decedent as a Medical Examiner (ME) case or has requested the physician submit this form for review. Please complete sections A, C, D & E.</p> <p><input type="checkbox"/> The HCF is requesting storage at OCME of a decedent until the next-of-kin are ready to claim the remains. This is considered a Chain-Only case where the method of disposition is "interment" and the place is "OCME Storage". Please complete sections A, B, C & D (Section E is not required).</p> <p><input type="checkbox"/> The decedent's next-of-kin is requesting City Burial for a decedent whose death is due exclusively to natural disease. This is considered a City Burial case where the method of disposition is "interment" and the place is "City Burial". Please submit the letter authorizing City Burial signed by the NOK with this form. Please complete sections A, C & D (Section E is not required).</p> <p>A. Demographics (please complete all fields)</p> <p>Last Name: _____ First Name: _____ Middle Name: _____ Sex: <input type="checkbox"/> Male / <input type="checkbox"/> Female <input type="checkbox"/> Other () _____ DOB (mm/dd/yyyy)* (Click to view dropdown calendar) <input type="checkbox"/> N/A <input type="checkbox"/> Unknown Religion: _____ Veteran: <input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> Unknown</p> <p>B. Next-of-Kin (NOK) Information (please complete all fields) (If all NOK are deceased, please provide information on next of kin available)</p> <p>NOK Last Name: _____ NOK First Name: _____ NOK Middle Name: _____ Relationship to decedent: _____ Was Family Headed? <input type="checkbox"/> Y / <input type="checkbox"/> N If No, # attempts made: _____ Family Present? <input type="checkbox"/> Y / <input type="checkbox"/> N Disposition to Autopsy? <input type="checkbox"/> Y / <input type="checkbox"/> N If yes, why? (Check One) <input type="checkbox"/> Religious <input type="checkbox"/> Personal Other # () _____</p> <p>C. Health Care Facility Data (please complete all fields)</p> <p>Health Care Facility (HCF) Name: _____ Admission Type (Check one): <input type="checkbox"/> ER <input type="checkbox"/> Inpatient <input type="checkbox"/> Long Term Care Transported by (Check one): <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> EMS Unit Admission Date: _____ Date: (click to view dropdown calendar) Time: _____ Address from where decedent was transported: _____ Primary Medical Doctor (PMD) Contact Info: _____ Last Name: _____ First Name: _____ Tel: () _____ Cell: () _____ Preprocessing Physician Contact Information: _____ Last Name: _____ First Name: _____ Tel: () _____ Cell: () _____ Death Pronounced: _____ OOD (mm/dd/yyyy)* (Click to view dropdown calendar) _____ Time: _____ * If patient was transported to a nursing home (NH), please contact the nursing facility and confirm the following from NH records: Funeral Arrangements available: <input type="checkbox"/> Y / <input type="checkbox"/> N Religion: _____ Veteran: <input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> Unknown NOK Last Name: _____ NOK First Name: _____ NOK Middle Name: _____ Relationship to decedent: _____ Nursing Name (NH) Name: _____ NH Reg Phone: () _____ NH Representative who confirmed information: _____ Last Name, First Name: _____ Title: _____</p> <p>Required documents must be attached: <input type="checkbox"/> Death Certificate (required for City Burial and Chain-Only) <input type="checkbox"/> Autopsy Report (required for City Burial and Chain-Only) <input type="checkbox"/> Discharge Summary or H&P (required for ME cases) <input type="checkbox"/> Subpoena for City Burial (required whenever City Burial is requested)</p> <p>Please do not attach additional medical records or otherwise unrelated documentation.</p> <p><small>Please be advised that failure to notify next-of-kin of the death of their loved one interferes with the NOK's right to direct final disposition without delay and may therefore be a violation of the NOK's right of disposition. NOTE: This form must accompany the decedent when transported to OCME. Version 3.0 last revised 10/16/2019</small></p>	<p>OCME Clinical Summary Worksheet Fax to OCME Communications 24/7 at (844) 500-5762</p> <p>D. Medical Examiner Reportable Death Criteria: For each question in Section D, please select "Yes" or "No" for the case you are reporting.</p> <p>The Office of Chief Medical Examiner (OCME) may choose to accept jurisdiction over deaths occurring under the following circumstances. See OCME Website for further guidance: http://www.nyc.gov/ocme/services/reporting-a-case-page</p> <p>yes <input type="checkbox"/> no <input type="checkbox"/> Is this death the result of a recent or old injury, accident, suicide, homicide, assault or therapeutic complication?</p> <p>yes <input type="checkbox"/> no <input type="checkbox"/> Does the decedent have any type of head trauma such as subdural hematoma or known seizure disorder?</p> <p>yes <input type="checkbox"/> no <input type="checkbox"/> Does the decedent have a prior chest injury, rib fracture, hernia, gunshot or stab wounds or any other trauma?</p> <p>yes <input type="checkbox"/> no <input type="checkbox"/> Did the decedent die from an overdose or intoxication from drugs, alcohol, chemicals or prescription drugs?</p> <p>yes <input type="checkbox"/> no <input type="checkbox"/> Did the decedent have any type of medical or surgical procedure that is known or suspected to have caused or contributed to the death?</p> <p>yes <input type="checkbox"/> no <input type="checkbox"/> Was the decedent under police custody, detained, a prisoner or involuntarily committed for psychiatric care?</p> <p>yes <input type="checkbox"/> no <input type="checkbox"/> Does the death pose a threat to public health, such as bacterial meningitis?</p> <p>yes <input type="checkbox"/> no <input type="checkbox"/> Did environmental temperature (high or low) contribute to the death?</p> <p>yes <input type="checkbox"/> no <input type="checkbox"/> Was the decedent transported from his or her workplace?</p> <p>yes <input type="checkbox"/> no <input type="checkbox"/> Is the decedent under the age of 18 years old (excluding intrauterine fetal demise)? If yes, age: _____</p> <p>yes <input type="checkbox"/> no <input type="checkbox"/> Is the decedent's identity unknown?</p> <p>yes <input type="checkbox"/> no <input type="checkbox"/> Was the decedent in apparent good health with no explanation for the death?</p> <p>yes <input type="checkbox"/> no <input type="checkbox"/> For intrauterine fetal demise, did maternal trauma, alcohol or drug abuse contribute to the death?</p> <p>The Office of Chief Medical Examiner (OCME) does not exert jurisdiction over deaths due exclusively to natural disease.</p> <p>yes <input type="checkbox"/> no <input type="checkbox"/> By selecting "yes" I hereby certify that the death was caused exclusively by natural disease.</p> <p>E. Clinical Summary (2019): Complete this section for ME cases only or city burial cases!</p> <p>Please summarize the circumstances and reasons for admission, past medical history, diagnostic work, surgical procedures and findings for all reportable deaths. Please report any bullet, alteration of record and forensic studies.</p> <p style="text-align: center; color: blue;">Complete this section for ME cases only</p> <p>By signing this form you are attesting that it is complete and accurate to the best of your knowledge and that the health care facility shall notify OCME as updated notification information becomes available.</p> <p>Prepared by: _____ Signature: _____ Date: _____ Title: _____ Department: _____ Contact #: _____</p> <p><small>Please be advised that failure to notify next-of-kin of the death of their loved one interferes with the NOK's right to direct final disposition without delay and may therefore be a violation of the NOK's right of disposition. NOTE: This form must accompany the decedent when transported to OCME. Version 3.0 last revised 10/16/2019</small></p>
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Where to find this form?

The OCME official website includes a “Case Reporting Criteria for Clinicians” page with the following information to assist the doctors calling to report deaths to our office:

1. Reportable Death Criteria
2. Procedures for Reporting Deaths ****the ME Clinical Summary Worksheet can be found here!****
3. Notes and Definitions for Physicians
4. DOHMH Training Resources to Improve Cause of Death Reporting

The URL is easy to remember: www.nyc.gov/ocmereportacase.

When to use this form?

The ME Clinical Summary Worksheet should be completed and provided to OCME for all cases under the following circumstances:

1. OCME has accepted jurisdiction of the death (*medical examiner or ME case*)
2. OCME has requested the form be completed because more information is necessary to determine if OCME will accept jurisdiction of the case
3. OCME has ***not accepted jurisdiction*** of the case ***and*** the health care facility (HCF) is requesting storage at OCME of the decedent until the next-of-kin (NOK) are ready to claim the remains (*claim only case*)
4. OCME has ***not accepted jurisdiction*** of the case ***and*** the NOK is requesting the remains be interred in the city cemetery at Hart Island (*city burial case*).

Who should complete this form?

The ME Clinical Summary Worksheet may be completed and signed by any HCF personnel responsible for the information therein.

How to complete this form?

General instructions

1. This form was developed to be completed on screen or it can be printed and all fields hand-written.
2. This form is formatted to print double-sided on letter (8 ½” x 11”) sized paper.
3. Please complete ***only*** the required sections.
4. Please follow the instructions provided in each section of this form.
5. Please complete every field in this form.
 - a. Please indicate unknown in fields where you do not have the requested information.
6. Please do not attach any additional medical records or otherwise unsolicited documentation.
7. If after reading the “*ME Clinical Summary Worksheet, Version 3.0 Instructions*” you require further assistance completing this form, please contact the OCME Communications Department personnel at (212) 447-2030.

- a. OCME Communications has staff available to assist 24 hours / day, 7 days / week.
- 8. Clinical physician staff needing assistance in completing death certificates for deaths in health care facilities should refer to the NYC Department of Health training materials at www.nyc.gov/ever. If they have never previously completed training in Death Certificate Completion they should click on “Training and Resources for Providers” and then “more information” under “Death Reporting” to find information about how to complete the Cause of Death. You may also access these resources via the OCME website at www.nyc.gov/ocmereportacase.

Instructions for Section: Why are you submitting this form?

1. Please indicate why you are submitting this form to OCME. By selecting only one of the options provided the Communications team will:
 - a. more quickly assess the form and forward it to the appropriate personnel for processing.
 - b. more quickly identify corrections that may be required in the related paperwork.
2. For claim only and city burial cases, please ensure that the method and place of disposition on the related death certificate and burial permit match the case type:

Case Type	Method of Disposition	Place of Disposition
Claim Only	Interim	OCME Morgue
City Burial	Interment / City Burial	City Cemetery at Hart Island

Instructions for Section A. Demographics

1. Please complete all fields in this section.
2. OCME requests any aliases known to be used by the decedent.
3. In date of birth (DOB) field OCME has added a drop down calendar for your convenience or you may simply type in the date.
 - a. For intrauterine fetal demise (IUFD), please provide the date of delivery.
 - b. Please indicate when the date of birth is an estimate.
4. OCME requires the medical record number for all decedents coming to OCME from a HCF.
5. OCME has added a drop down for the race field for your convenience or you may simply type it in.

Instructions for Section B. Next-of-Kin

1. Please complete all fields in this section.
2. Where the NOK are known, the HCF must notify the NOK of the death. **Failure to notify NOK of the death of their loved one interferes with the NOK’s right to direct final disposition without delay and may therefore be a violation of the NOK’s right of sepulchre.**
 - a. If the HCF was unable to reach the NOK, all notification attempts must be documented.
3. Please identify if the NOK is objecting to autopsy along with the reason for the objection.
4. Please select the burial wishes as identified by the NOK.
 - a. Please note that if the NOK requests city burial for their loved one, OCME requires authorization for city burial signed by the NOK or person authorized to direct disposition.

5. Where the NOK are unknown and the HCF is requesting storage at OCME of the decedent for claim only, the HCF shall notify the Public Administrator (PA) of the death and document notification as indicated.
6. If the patient was admitted or resided in a nursing home (NH), the HCF shall contact the nursing facility and document all details in this section as recorded by the nursing home.
7. Please provide all available contact information for NOK, PA and NH so that OCME can follow up, as appropriate.
8. Please notify OCME as updated information becomes available.

Instructions for Section C. Health Care Facility Data

1. Please complete all fields in this section.
2. Please provide the name of the HCF submitting this form.
 - a. If your facility is required to use the electronic death registration system, please submit the name of your HCF as it is registered with the Department of Health.
3. In the patient admitted field please use the drop down calendar for your convenience or you may simply type in the date.
4. Please provide all available contact information for the primary medical doctor (PMD) and pronouncing physician, if different from the PMD.
5. In the death pronounced field please use the drop down calendar for your convenience or you may simply type in the date.
 - a. For IUFD, please provide the date of delivery.
6. This form will recognize 24 hour time entries and will convert them to the 12 hr.
 - a. Please select AM / PM for all time entries.
7. Please submit *only* the documents requested based upon the case type. Please do not attach any additional medical records or otherwise unsolicited documentation.

Document Type	Required for the Following Case Types
HCF Face Sheet	All cases (ME, claim only & city burial)
EMS Patient Care Report (PCR) / Ambulance Call Report (ACR)	ME cases only
Discharge Summary and/or Admission records	ME cases only
History and Physical Examination (H&P)	ME cases only
Death Certificate	Claim only & city burial cases
Burial Permit	Claim only & city burial cases
Authorization for city burial <i>Must be signed by the NOK or person directing disposition</i>	City burial cases only

Instructions for Section D. Reportable Death Criteria

1. Please select 'Yes' or 'No' for each of the questions in section D.

Instructions for Section E. Clinical Summary

1. Section E should *only* be completed in the following circumstances:
 - a. for an ME case
 - b. where OCME has requested that the physician submit the ME Clinical Summary Worksheet for review.

How to submit this form?

1. Please print, sign and date this form providing all contact information for the signatory.
2. Please fax the completed and signed ME Clinical Summary Worksheet to the OCME Communications Department at (646) 500-5762.
 - a. OCME Communications has staff available to assist 24 hours / day, 7 days / week.
3. Once the completed and signed ME Clinical Summary Worksheet has been received OCME Communications will provide the case number.
4. The *original and signed* form must accompany the decedent for transport to the Medical Examiner's office.