

# Hospice: Pre-Registration and Report of Death

## Southern Minnesota Regional Medical Examiner's Office

This form is for hospice patients expected to die outside of a hospital or licensed nursing home facility.

**Instructions:** Complete pre-registration portion of the form upon registering patient with hospice agency. Email completed pre-registration to [DLRSTPRSMEODA@mayo.edu](mailto:DLRSTPRSMEODA@mayo.edu) or fax to 507-266-6658.

Registering Hospice Agency Name	Registration and Residence County	Registration Date (mm-dd-yyyy)
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### Pre-Registration

Patient Name (First Middle Last)		
Birth Date (mm-dd-yyyy)	Sex Assigned at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Choose not to disclose	
Attending Provider Name (First Middle Last)		
Attending Hospital Name		Registration Number
City	State	Phone
Anticipated Terminal Diagnosis and Comorbidities (be specific)		
<input type="checkbox"/> <b>Legal next of kin</b> (If there is no living spouse, list any living adult children as legal next of kin.) <input type="checkbox"/> <b>Legal person appointed under MN Statute 145C</b> (Fax a copy with pre-registration form.)		
Name (First Middle Last)		Phone

**Instructions:** Complete death reporting portion of the form within 12 hours of patient death. Email completed form to [DLRSTPRSMEODA@mayo.edu](mailto:DLRSTPRSMEODA@mayo.edu) or fax to 507-266-6658.

### Death Reporting

Death Place (for example, decedent residence, assisted living, hospice house)			Death Date (mm-dd-yyyy)
Address			Death Time (hh:mm 24-hour clock)
City	County	State	ZIP Code
Were any of the following conditions present (regardless of time)?			
<input type="checkbox"/> Fall, injury, or other trauma resulting in fracture or neurologic disorder	<input type="checkbox"/> Neglect/Abuse	<input type="checkbox"/> Rhabdomyolysis	
<input type="checkbox"/> Neurogenic bladder	<input type="checkbox"/> Traumatic brain injury	<input type="checkbox"/> Gunshot wound	
<input type="checkbox"/> Paraplegia/Quadriplegia	<input type="checkbox"/> Mesothelioma (asbestos or work-related exposures)	<input type="checkbox"/> Suicide attempt	
<input type="checkbox"/> Choking/Dysphagia due to trauma	<input type="checkbox"/> Work-related injury	<input type="checkbox"/> Medication error	
<input type="checkbox"/> Suspicious circumstances/homicide			
<b>If any box is checked, the death must be reported to the Medical Examiner's Office via Law Enforcement Dispatch in the county of death.</b>			
<input type="checkbox"/> No ME reportable criteria			
Investigator Contacted			Medical Certifier <input type="checkbox"/> Medical examiner <input type="checkbox"/> PCP