Complete and print.

Reset Form

MAYO CLINIC

Licensed Nursing Home Death Reporting

Form content not retained in medical record.
Discard after use.

(complete fields or place patient label here)

Patient Name (First Middle Last)	
Birth Date (mm-dd-yyyy)	Room Number (if applicable)
Mayo Clinic Number	

Instructions: This form should be filled out at the time of patient death. For use by licensed nursing homes in which the patient is under the care of a provider of Mayo Clinic in Rochester.
Fax completed form to 507-266-6757, or save and email to rstofficedecaff@mayo.edu within 2 hours of death.

Important: Include diagnoses list and perimortem nursing notes (includes 3 days prior to death).

Death Date (mm-dd-yyyy)	Death Time (hh:mm) ☐ am ☐ pm

Individual Reporting Death

Name (First Middle Last)	Phone	Date (mm-dd-yyyy)	Time (hh:mm) ☐ am ☐ pm

☐ **Check if hospice patient** (continue to complete form). **Hospice agency name** _____

Hospice Certifying Provider Name (First Middle Last)

Death Location

Facility Name	Address (Street, City, State, ZIP Code)	Phone

Legal Next of Kin Information

Name (First Middle Last)	Relationship to Deceased	Phone

Funeral Home

Name	Phone

Autopsy or Anatomical Bequest Requested

☐ No ☐ Yes – contact the Office of Decedent Affairs at **507-293-7800**: ☐ Advance Directive ☐ Legal next of kin consent

Medical Examiner (ME) Reportable Criteria

Were any of the following conditions present, regardless of time?

☐ No ME reportable criteria

☐ Fall, injury, or other trauma resulting in fracture of neurologic disorder
☐ Neurogenic bladder
☐ Paraplegia or quadriplegia
☐ Choking or dysphagia due to trauma
☐ Neglect or abuse
☐ Traumatic brain injury
☐ Mesothelioma (asbestos or work-related exposure)
☐ Work-related injury
☐ Rhabdomyolysis
☐ Gunshot wound
☐ Suicide attempt
☐ Medication error
☐ Potentially non-natural circumstances or homicide

If any condition is selected, the death must be reported to Medical Examiner's Office via Law Enforcement Dispatch at 507-285-8580.

If Reported, Investigator Name (First Middle Last)

For Office Use Only

ADRC ☐ Yes ☐ No	ODA Review – Initials	ME Signing ☐ Yes ☐ No	DI Initials

Print