



LA CROSSE COUNTY MEDICAL EXAMINER 24 HOUR NON-TRAUMATIC DEATH ADVISORY FORM

PATIENT INFORMATION

Name:		Gender:	DOB:
Address:	Age:	Soc #	
City/State/Zip		Primary Physician:	

DEATH INFORMATION

Date of Death:	Time of Death:	Physician Pronouncing:
Date of Admission:	Staff Who Found Decedent:	Title:
Cause: <i>(Natural is not acceptable)</i>		Civil Status <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> S

MEDICAL HISTORY

1. What was this patient's primary, admitting diagnosis? _____

2. Has this patient suffered any trauma, falls or fractures? Yes No

3. If yes, what type of trauma? _____

4. Did the patient return to pre-trauma status? Yes No NA

Any patient who has suffered trauma, falls or fractures and did not return to pre-trauma status will require a Medical Examiner response. All others deaths can be forwarded via fax to the Medical Examiner's Office. If there are questions, please contact the on-duty Coroner at anytime.

5. Does this patient have a differential diagnosis? And if so, what? _____

NOTIFICATIONS:

Next of Kin:	Notified by:	Relationship:
Address:	City/State/Zip	Telephone:
Funeral Home Choice:	City	Expected Disposition: <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Unsure

Person completing this form _____

Date _____

Phone Number _____