A. Patient Information:

Name of Deceased: ____ Birth Date: ___/___/___ Age: ___ Male ☐ Female ☐

Social Security #: ___/___/___ Date / Time of Death: ___ Pronounced by: ___

Attending Physician: ___ Telephone: (___) ___ Admitting Dx: ___ Reason for Death: ___

Physician signing Death Certificate: ___ per ___ Telephone: (___) ___

Person responsible for deceased ___ Telephone: (___) ___

Address ___ City ___ State ___ Zip ___ Relationship ___

Did patient have infectious disease? No ☐ Yes ☐ If yes, please specify ___

Special Isolation Precautions needed? No ☐ Yes ☐ If yes, please specify ___

B. Pursuant to FL. Statute, contact LIFELINK / LIONS @ 1-800-643-6667 (or 932-8808) prior to completing this form

Date: ___ Time called: ___ Lifelink Representative: ___ Staff Signature ___

Name of Lifelink Coordinator returning call: ___ Time call returned: ___

Pt. medically suitable as determined by Lifelink? ☐Yes If yes, hold for donor. ☐No If no, state reason and release to Funeral Home:

___

C. Medical Examiner Review @ 813-272-6377

Medical Examiner case? ☐ Yes ☐ No Nursing Supervisor: ___

M E. contacted for questionable case by: ___ Date: ___ Time called: ___

☐ Declined or ☐ Accepted per ___

Name of family notified of acceptance: ___

Pacemaker ☐ Yes ☐ No

Medical Examiner guideline:

- DOA ☐ Yes ☐ No
- New admit (w/o med hx) ☐ Yes ☐ No
- Injury within last month ☐ Yes ☐ No
(falls, trauma, accident: Home __ Hospital __)
- Surgical related ☐ Yes ☐ No
- Work related ☐ Yes ☐ No
- Poison or OD ☐ Yes ☐ No
- Evidence-criminal abortion ☐ Yes ☐ No

D. Autopsy Information

Autopsy to be performed? ☐ Yes ☐ No Autopsy requested by: ___

If yes, Consent obtained? ☐ No ☐ Yes UCH Pathology notified? Time ___ Name: ___

Post-autopsy, body released by Pathology and Funeral Home notified: Time: ___ Name: ___

E. Personal Belongings

	Yes	No	To Security	To Family	To Transport	Description/Specific Information
Eyeglasses						
Dentures						
Clothing						
Valuables						
Other						

Newborn Death

Apgars: ___ 1 ___ 5 (Baby Only)

Time of Birth ___

Estimated Gestational Age ___

Comments

F. Authorization to Remove Body (Leave section blank if funeral home not selected)

I authorize ___ **to remove the body of** ___

Funeral Home/Lifelink/Medical Examiner — Name of Deceased

Signature ___ **Relationship** ___ **Date:** ___ **Time:** ___

Witness: ___ **Witness** ___

G. Funeral Home Notification by Nursing Office Date: ___ **Time called:** ___ **Staff Name:** ___

Name of Funeral Home Rep notified: ___

Body transport service signature ___ Storage certificate filed if held 3 days ___

Released by: ___ Date: ___ Time: ___

EXPIRATION SUMMARY/BODY RELEASE PERMIT

University Hospital

Addressograph

C4210 (Was Q049)
Rev. 3/29/04

White - Chart *Canary - Nursing Office* *Pink - Funeral*