Pre-Registration

Southern Minnesota Regional Medical Examiner's Office

For hospice patients expected to die outside of a hospital or licensed nursing home facility.
Instructions: Please **type** or **print clearly** and complete **entirely** or form will be returned. **Fax** to 507-266-6658.

Patient Name *(Last, Full Legal First, Middle)*			
Address			
City	State	ZIP Code	County
Phone *(xxx-xxx-xxxx)*	Birth Date *(Month DD, YYYY)*		Sex ☐ Male ☐ Female
Marital Status ☐ Married ☐ Widowed ☐ Divorced ☐ Never Married			

☐ **Legal Next-of-Kin** (If there is no living spouse, list any living adult children as legal next of kin.)
OR
☐ **Legal Person Appointed Under MN Statute 145C** (Please fax a copy with pre-registration form.)

Name *(Last, Full Legal First)*		Relationship
Address		Phone *(xxx-xxx-xxxx)*
City	State	ZIP Code

Attending Physician *(The physician who is signing the death certificate)*	Clinic Name
Phone *(xxx-xxx-xxxx)*	Date Last Seen *(Month DD, YYYY)* (Must be within 180 days)
Anticipated Terminal Diagnoses and Co-Morbidities *(Be Specific)*	
Current Controlled Substances Prescribed to Patient	
Any Falls/Injuries Resulting in Fractures or Neurological Change in the Past Six Months? ☐ Yes ☐ No If yes, describe	
Registering Agency *(Must be a Class D Licensed Hospice Agency)*	License Number
Registered By *(Last, First) (Print)*	
Phone *(xxx-xxx-xxxx)*	Fax
Is the patient interested in eye or tissue donation: ☐ Yes ☐ No If yes, call 1-800-24-SHARE	

For Medical Examiner Office Use Only

Date Received	Accepted By