Cuyahoga County Medical Examiner's Office
11001 Cedar Avenue, Cleveland, Ohio 44106

Telephone # 216-721-5610
Fax # 216-707-3188
[TTY] Ohio Relay Service #1-800-750-0750

REPORT TO THE MEDICAL EXAMINER

Section 313.11 and 313.12, Revised Code of the State of Ohio

This form must accompany the body to the Medical Examiner's Office

HOSPITAL CHART NO.______________________________ DATE:______________________

FROM:______________________________HOSPITAL Inpatient ________ Emergency Room ________ DOA ________

STATEMENT AND PARTICULARS IN THE DEATH OF:______________________________

Home address:______________________ Admitted______________________ at _________ AM _________ PM
(Date mo/day/year)

Conveyed to hospital by: (Ambulance, Taxi, Private car etc.): ______________________ Unit number, if any: ____________

From: ______________________________ (residence, public place, jail, etc)

Address conveyed from: ______________________________
Number Street Apt. # City County

Race: ____________ Occupation:______________________ Age: __________ Years _________ Months _________ Days _________

Married Single Widowed Divorced: ______________________________
(Circle One) Name and telephone # of surviving spouse or significant other

THE SECTION BELOW MUST BE COMPLETED IN FULL (DO NOT WRITE SEE CHART, SEE LIST, ETC.)

Admitting Physician: ______________________________, MD/DO

Chief Complaints: ______________________________

Principal Diagnosis: ______________________________

Past Medical & Surgical History: ______________________________

____

Current Medical Diseases: ______________________________

Prescription and/or Illicit Drugs used by patient:: ______________________________

Medications administered: ______________________________

Is death from NATURAL CAUSES: YES or NO

IF NO, manner injuries were received: ______________________________

____

Therapy instituted (including any operative procedures):______________________________

____

____

Were any foreign bodies recovered? YES / NO / N/A

If the patient did not recover from anesthesia, was the patient conscious prior to induction? YES / NO / N/A

DEATH TOOK PLACE ON THE __________DAY OF______________________MONTH, 200___, at __________ AM __________ PM

In your opinion, what is the probable cause of death:______________________________

____

____

Pronouncing Physician:______________________________, ______________________________,M.D./D.O.
Printed Name Signature