PathCare PLLC

POST-MORTEM EXAMINATION DATA SHEET

Decedent Name: _____ Date of Death: _____ Time of Death: _____

County of Death: _____ State of Death: _____ Location of Death: _____

Date of Birth: _____ Age: _____ Race: _____ Sex: _____

Funeral Home: _____ Embalmed: □ Yes □ No Final Disposition: □ Burial □ Cremation Phone #: _____

REASON FOR EXAMINATION

□ Cause of Death □ Family Medical Concern □ Surgical Evaluation
□ Identification □ Legal Purposes □ Donation / Research

Attorney: _____ Firm Name: _____ Phone #: _____

MEDICAL INFORMATION

Name of Medical Facility: _____ Location: _____ Phone #: _____

Primary Care Physician: _____ Address: _____ Phone #: _____

□ Recent Falls/Injuries Date: _____ □ Recent Surgeries Date: _____ □ Work Related _____

MEDICAL HISTORY

□ None □ Asthma □ Bleeding Disorder □ Cancer □ CVA / TIA
□ Diabetes □ Dialysis □ Gastrointestinal □ Hepatitis □ Hypertension
□ HIV+ □ Headaches □ Substance Abuse □ Seizures □ Tuberculosis
□ Unknown Heart Disease □ Unknown Lung Disease □ Pacemaker
□ Unknown Brain Disease □ Unknown Kidney Disease □ Insulin/Pain Pump
□ Unknown Liver Disease □ Unknown Skeletal Disease □ Stents

If "Marked", Please Explain: _____

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