OCME Clinical Summary Worksheet **Fax to OCME Communications 24/7 at (646) 500-5762**

Why are you submitting this form?

Please indicate why the health care facility (HCF) is submitting the Clinical Summary Worksheet to OCME Communications.
Please check only one of the following options:

☐	OCME has accepted jurisdiction of this decedent as a **Medical Examiner (ME) case** or has requested the physician submit this form for review. *Please complete sections A, B, C, D & E*
☐	The HCF is requesting storage at OCME of a decedent until the next-of-kin are ready to claim the remains. This is considered a **Claim Only case where the method of disposition is "interim" and the place is "OCME Morgue"**. *Please complete sections A, B, C & D (section E is not required)*
☐	The decedent's next-of-kin is requesting **City Burial** for a decedent whose death is due exclusively to natural disease. This is considered a **City Burial case where the method of disposition is "interment" and the place is "City Burial".** Please submit the **letter authorizing City Burial signed by the NOK** with this form. *Please complete sections A, B, C & D (section E is not required)*

A. Demographics

A. Decedent Demographics: ***please complete all fields***

Last Name:		**First Name:**	**Middle Name:**
Alias:		**DOB (mm/dd/yyyy)*:** **For intrauterine fetal demise (IUFD), please provide the date of delivery*	**MRN #:**
Religion:	**Sex:** ☐ **Male /** ☐ **Female**	**Race:** Unknown	**Veteran:** ☐ **Y /** ☐ **N /** ☐ **Unknown**

B. Next-of-Kin

B. Next-of-Kin (NOK) Information: ***please complete all fields. PLEASE NOTIFY OCME AS UPDATED INFORMATION BECOMES AVAILABLE***

NOK Last Name:	**NOK First Name:**		**Tel: ( ) -**
Relationship to decedent:	**Was Family Notified?** ☐ **Y /** ☐ **N**	**If No, # attempts made:**	**Family Present?** ☐ **Y /** ☐ **N**
Objection to Autopsy? ☐ **Y /** ☐ **N**	**If yes, why? (Check One):** ☐ **Religious** ☐ **Personal**		**Other #: ( ) -**

The below additional information MUST be provided for all *Claim Only cases* in which next-of-kin is unknown.

Public Administrator Referral Date:	**Name of PA staff notified:**	**Borough:** Richmond

If patient was admitted from or resided in a nursing home (NH), please contact the nursing facility and confirm the following from NH records:

Funeral Arrangements available: ☐ **Y /** ☐ **N**	**Religion:**	**Veteran:** ☐ **Y /** ☐ **N /** ☐ **Unknown**
NOK Last Name:	**NOK First Name:**	**NOK Phone: ( ) -**
Relationship to decedent:	**Nursing Home (NH) Name:**	**NH Rep Phone: ( ) -**
NH Representative who confirmed information	**Last Name, First Name:**	**Title:**

C. Health Care Facility Data

C. Health Care Facility Data: ***please complete all fields***

Health Care Facility (HCF) Name:			
Admission Type (Check one): ☐ **ER** ☐ **Inpatient** ☐ **Long Term Care**		**Transported by (Check one):** ☐ **Self** ☐ **Family** ☐ **EMS Unit**	
Admission:	**Date:**		**Time:** PM
Address from where decedent was transported:			
Primary Medical Doctor (PMD) Contact Info:	**Last Name:**		**First Name:**
	Tel: ( ) -		**Cell: ( ) -**
Pronouncing Physician Contact Information:	**Last Name:**		**First Name:**
	Tel: ( ) -		**Cell: ( ) -**
Death Pronounced:	**DOD (mm/dd/yyyy)*:** **For intrauterine fetal demise (IUFD), please provide the date of delivery*		**Time:** PM
Required documents must be attached:	☐ **Face Sheet** *(required for **ALL** cases)*	☐ **EMS Patient Report (PCR)** *(required for **ME cases**)*	☐ **Discharge Summary or H&P** *(required for **ME cases**)*
	☐ **Death Certificate** *(required for **City Burial and Claim Only**)*	☐ **Burial Permit** *(required for **City Burial and Claim Only**)*	☐ **Authorization for City Burial** *(required **whenever City Burial is requested**)*

Please do not attach additional medical records or otherwise unsolicited documentation.

Please be advised that failure to notify next-of-kin of the death of their loved one interferes with the NOK's right to direct final disposition without delay and may therefore be a violation of the NOK's right of sepulchre.
NOTE: This form must accompany the decedent when transported to OCME.
Version 3.0 Last revised 10/01/2019

D. Reportable Death Criteria

D. Medical Examiner Reportable Death Criteria: For each question in Section D, please select Yes or No for the case you are reporting.

The Office of Chief Medical Examiner (OCME) may choose to exert jurisdiction over deaths occurring under the following circumstances.
See OCME Website for further guidance: http://www1.nyc.gov/site/ocme/services/reporting-a-case.page

yes	☐	*no*	☐	Is this death the result of a recent or old injury, accident, suicide, homicide, assault or therapeutic complication?
yes	☐	*no*	☐	Does the decedent have any type of head trauma such as subdural hematoma or known seizure disorder?
yes	☐	*no*	☐	Does the decedent have a spinal cord injury, hip fracture, burns, gunshot or stab wounds or any other trauma?
yes	☐	*no*	☐	Did the decedent die from an overdose or intoxication from drugs, alcohol, chemicals or prescription drugs?
yes	☐	*no*	☐	Did the decedent have any type of medical or surgical procedure that is known or suspected to have caused or contributed to the death?
yes	☐	*no*	☐	Was the decedent under police custody, detained, a prisoner or involuntarily committed for psychiatric care?
yes	☐	*no*	☐	Does the death pose a threat to public health, such as bacterial meningitis?
yes	☐	*no*	☐	Did environmental temperature (high or low) contribute to the death?
yes	☐	*no*	☐	Was the decedent transported from his or her workplace?
yes	☐	*no*	☐	Is the decedent under the age of 18 years old (*excluding intrauterine fetal demise*)? *If yes, age:*
yes	☐	*no*	☐	Is the decedent's identity unknown?
yes	☐	*no*	☐	Was the decedent in apparent good health with no explanation for the death?
yes	☐	*no*	☐	For intrauterine fetal demise, did maternal trauma, alcohol or drug abuse contribute to the death?

The Office of Chief Medical Examiner (OCME) does not exert jurisdiction over deaths due exclusively to natural disease.

yes	☐	*no*	☐	By selecting "yes" I hereby certify that this death was caused exclusively by natural disease.

E. Clinical Summary

E. Clinical Summary: STOP - Complete this summary for Medical Examiner Cases only!

Please DO NOT complete this section for claim only or city burial cases!

Please summarize the circumstances and reasons for admissions, past medical history, diagnostic work, surgical procedures and findings for all reportable deaths. Please report any bullets, alterations of wounds and toxicology studies.

Complete this section for ME cases only

By signing this form you are attesting that it is complete and accurate to the best of your knowledge and that the health care facility shall notify OCME as updated next-of-kin information becomes available.

Prepared by _____ Signature _____ Date _____

Title _____ Department _____ Contact # _____

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