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