

**LAURIE H. SUMMERS, R.N.**

**CORONER OF WILL COUNTY, ILLINOIS**



**HOSPICE PRE-REGISTRATION FORM**

NEW

READMISSION

UPDATE

Reporting Agency: \_\_\_\_\_

Agency Phone Number: \_\_\_\_\_ Date of report: \_\_\_\_\_

**Patient Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex: \_\_\_\_\_ Race: \_\_\_\_\_ SSN: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Patient Location: \_\_\_\_\_

(Ex.: residence, name of hospital, name of nursing home, hospice home, or specify other)

**Next of Kin Information:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Date of Admission to Hospice: \_\_\_\_\_ Registrar: \_\_\_\_\_

Terminal Diagnosis: \_\_\_\_\_

Comorbidity: \_\_\_\_\_  
\_\_\_\_\_

Attending Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Funeral Home: \_\_\_\_\_ Phone: \_\_\_\_\_

Are there any falls, trauma, injuries, or overdoses to report that may have contributed to the terminal diagnosis given above? (Ex.: delayed death due to car accident, homicide or suicide, near drowning, drug overdoses, surgical misadventure, paraplegia, anoxic encephalopathy, history of fall with fractures or head injuries, aspiration of food or foreign object)  No  Yes

Any signs of abuse or neglect?  No  Yes

**If the answer is yes to any of these questions you MUST notify the Coroner at time of death at (815)727-8455**

Please fax this completed form to the Will County Coroner's Office at (815)727-8816 within 24 hours of patient admission.

**FOR OFFICE USE ONLY**

Follow up by: \_\_\_\_\_

Date: \_\_\_\_\_

Contact & Notes: