COHESIVE HEALTHCARE MANAGEMENT & CONSULTING
MANGUM REGIONAL MEDICAL CENTER
Deceased Patient Checklist (retain in medical record) (NUR-009)

Name of Deceased: ____________________ Medical Record Number: ____________ Date of Death: ________

Please review the patient's medical record to see if this patient died due to or a delayed consequence of any of the following suspected causes or under any of the following circumstances:

	Yes	No		Yes	No
Violent (homicidal, suicidal, accidental/casualty, including but not limited to thermal, chemical, electrical, radiation, deaths due to criminal abortion (self-induced or not; maternal/fetal)			Medically unexpected and that occur in the course of a therapeutic procedure		
Suspicious, Unusual, Unnatural Circumstances			Deaths of inmates occurring in penal incarceration		
Disease that may constitute a public health threat			Unexplained Coma		
Unattended by a licensed medical/osteopathic physician for a fatal/potentially fatal illness			Bodies for cremation/burial at sea, transported out of state, or otherwise unavailable for pathological study		

If the answer to any of the above listed questions is "Yes," notify the medical examiner/coroner before the deceased body is removed from place of death. All therapeutic items must be left in place until ME/Coroner has authorized removal. Retain all personal items of the deceased and release to family after authorization by the ME/Coroner. ME/Coroner number: Name of County ME (xxx) xxx-xxxx**. Ok Stat Ann. 63.938**

Name of Medical Provider pronouncing death: ____________________ Time: ________

Name of Attending/Admitting Physician: ____________________

Was the Attending/Admitting Physician notified? □ Yes □ No Time: ____________
By Whom: ____________________

Name of ME/Coroner notified: ____________________ Time: ____________

Notify LifeShare Oklahoma within 1 hour of death or imminent death to determine medical suitability for donation: 1-800-241-4483.

Name of Contact at OPO agency: ____________________ Referral Number: ____________

Date Contacted: ____________ Time Contacted: ____________

Eligible: □Yes □No □ Corneas □ Organ □ Tissue □ Non-Candidate □ Family Refused □ Coroner/ME refused

Physician or Family Request for Autopsy □ Yes □ No Permit Signed □ Yes □ No

Family Member/Patient Representative notified: Name: ____________________ Time: ________
Chaplin/Clergy notified: ____________________ Time: ________
Name of Funeral Home: ____________________ Time: ________

Signature of Nurse completing checklist: ____________________
Date: ____________ Time: ____________

Body Received By (signature): ____________________
Date: ____________ Time: ____________

COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

NAME OF HOSPITAL

HEALTHCARE

Body Release Form

(retain in medical record)

Mangum Regional Medical Center is hereby authorized to release the body of:

______________________________ to ______________________________
(funeral home)

Name of Family Member/Patient Representative notified: ______________________

Relationship to Deceased: ______________________

Date Contacted: ______________ Time notified: ______________

Date of Expiration: ______________ Time of Expiration: ______________

Name of Physician notified: ______________________

Date & Time Physician notified:______________________

Post Mortem Care: ☐ Yes ☐ No

List of personal belongings: ______________________________

____

____

Belongings given to: ______________________

Signature of Family/Personal Representative: ______________________

Date: ______________ Time: ______________

Body picked up by: ______________________

Date: ______________ Time: ______________

Signature of Nurse: ______________________

Date: ______________ Time: ______________