CALI HOME FUNERAL SERVICES FD#2057

7401 PRINCESS VIEW DR., SAN DIEGO, CA 92120

FAXED:

From _____- PHONE # _____ FAX # **(888)-245-5399**

URGENT- CAUSE OF DEATH WORKSHEET

ONCE COMPLETED, FAX BACK IMMEDIATELY TO MORTUARY (N ABOVE)

DOCTOR _____ **LIC #** _____

PHONE #_____ **FAX#**_____

ADDRESS:_____ **CITY**_____ **ZIP**_____

Doctor, please complete this worksheet and fax back to our office ASAP. Once the causes are cleared with the local health dept., you will receive the "Physician Attestation" copy for your signature or voice attestation.

DECEDENT:_____ __M__F

DATE OF BIRTH:_____ **SS#:**_____

DATE OF DEATH:_____ **TIME OF DEATH:**_____

PLACE OF DEATH

101 PLACE OF DEATH	102. IF HOSPITAL, SPECIFY ONE ☐ IP ☐ ER/OP ☐ DOA	103. IF OTHER THAN HOSPITAL. SPECIFY ONE ☐ Hospice ☐ Nursing Home/LTC ☐ ecedent's Home ☐ Other
104. COUNTY	105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number or location)	106. CITY

CAUSE OF DEATH

107. CAUSE OF DEATH Enter **the chain of events --- diseases, injuries, or complications -- that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.**

		Time interval between Onset and Death
IMMEDIATE CAUSE (Final Disease or condition resulting in death)		(AT)
Sequentially, list condition, if any, leading to cause on line A.	(B)	(BT)
Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	(C)	(CT)
	(D)	(DT)

108. DEATH REPORTED TO CORONER YES ☐ NO ☐ REFERRAL NUMBER: _____

109. BIOPSY PERFORMED? ☐ YES ☐ NO

110. AUTOPSY PERFORMED? ☐ YES ☐ NO

111. USED IN DETERMININGCAUSE? ☐ YES ☐ NO

112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107

113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.)

113A. IF FEMALE. PREGNANT IN LAST YEAR? YES ☐ NO ☐ UN ☐

PHYSICIAN'S CERTIFICATION,

114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR. DATE AND PLACE STATED FROM THE CAUSES STATED.	115. SIGNATURE AND TITLE OF CERTIFIER	116. LICENSE NUMBER	117. DATE mm/dd/ccyy

(A) Decedent Attended Since mm/dd/ccyy	(B) Decedent Last Seen Alive mm/dd/ccyy	118. TYPE ATTENDING PHYSICIAN'S NAME. MAILING ADDRESS, ZIP CODE

TIMEFRAME FOR WORKSHEET COMPLETION: In accordance with the Health & Safety code, Section 102800, the physician must complete the medical and health section within **15 hours** after the patient dies. The responsibility extends to a physician's designee, as applicable.