

THIS IS A NEW YORK CITY GOVERNMENT RECORD
AND SHOULD BE ACCURATELY COMPLETED BY HOSPITAL STAFF
NOTE: Form must accompany body transported to Medical Examiner's Office.

M.E. #: _____ / _____ / _____

1 Name of Hospital _____ Medical Record # _____

Name of Deceased _____ Age: _____ Race: _____ Sex: _____

Street Address, Apt. No., City, State Zip Code _____

Next of Kin _____ Phone: (_____) _____

HOSPITAL COURSE

Date and Time of Admission _____

Pronounced by _____

Date and Time of Death _____

Attending Physician _____

Phone number (_____) _____

Please summarize: Circumstances and reasons for admission; admission clinical presentation; details of hospital course including diagnostic work-up surgical procedures and findings, including dates, recovery of bullets, alterations of wounds, etc.; and changes in clinical status:

Reporting Physician