CALI HOME FUNERAL SERVICES FD#2057

4683 Mercury St., Suite A, San Diego, CA 92111

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

URGENT- CAUSE OF DEATH WORKSHEET

ONCE COMPLETED, FAX BACK IMMEDIATELY TO MORTUARY

DOCTOR _____ LIC # _____

PHONE # FAX#

_____ _____

ADDRESS STE# 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	103. IF OTHER THAN HOSPITAL. SPECIFY ONE
	☐ IP ☐ ER/OP ☐ DOA	☐ Hospice ☐ Nursing ☐ ecedent' s ☐ 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	108. DEATH REPORTED TO CORONER
IMMEDIATE CAUSE (Final Disease or condition resulting in death)	(A)	(AT)	☐ YES ☐ NO REFERRAL NUMBER
Sequentially, list condition, if any, leading to cause on line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	(B)	(BT)	109. BIOPSY PERFORMED? ☐ YES ☐ NO
	(C)	(CT)	110. AUTOPSY PERFORMED? ☐ YES ☐ NO
	(D)	(DT)	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? ☐ NO ☐ UNK

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

FAXED:

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.