

Reminder: Pain assessment and reassessment

- Pain rating must be documented prior to the administration of PRN pain medication.
 - Pain rating levels are reassessed within 1 hour after PRN pain administration by any route.
 - To help caregivers complete this documentation within 1 hour of administration, the pain reassessment reminder task will fire 30 minutes after administration.
 - Utilize critical thinking skills to determine reassessment timing based on the route of administration. Example: PO medication reassessment completed 30 minutes after administration. IV medication reassessment completed 15 minutes after administration. **No reassessment should be completed 1 minute after administration.**
- The pain/treatment plan is evaluated on an on-going basis and is revised to facilitate achievement of pain goals.

Medications

02/01/2024 14:39 EST	02/01/2024 14:10 EST	02/01/2024 14:09 EST
PRN	PRN	PRN
morphine	Pain Response	1 mg
1 mg, Inj, IV Push, Q3HR, PRN, pain scale 4-6, 02/01/24 14:08:00 EST	Last given: 02/01/24 14:09 EST	
morphine		1 mg IV Push Fore
Pain Assessment Pain Rating		7 Auth (Verified)
POSS Sedation		0 Auth (Verified)
Informed of Med purpose		Patient/family/key

Fires 30 minutes after administration

02/01/2024 14:39 EST

Intervention Info:
morphine
Performed by Train, Nursing-RN 1 on 02/01/24 14:09:00 EST

morphine, 1mg
IV Push, Forearm Left, pain scale 4-6

Pain - Post Assessment

Patient Stated Medication Effectiveness	Temperature (F)	Temperature (C)	Temperature Method
<input checked="" type="radio"/> Yes	98.6°F		<input type="radio"/> Tympanic
<input type="radio"/> No			<input type="radio"/> Rectal
<input type="radio"/> Other:			<input type="radio"/> Skin Sensor
Blood Pressure mmHg / mmHg	Mean Arterial Pressure	Heart Rate bpm	<input type="radio"/> Axillary
			<input type="radio"/> Temporal Scanner
			<input type="radio"/> Core
Medication administered for pain?			
<input checked="" type="radio"/> Yes			
<input type="radio"/> No			
Pain Scale Used	Pain Rating	Goal for Pain Management	
<input checked="" type="radio"/> 0-10	<input type="radio"/> 0	<input type="radio"/> No pain=0	
<input type="radio"/> CPOT (Critical Care Pain Obs Tool)	<input type="radio"/> 1	<input type="radio"/> Mild pain=1	
<input type="radio"/> Non-Verbal Pain Indicators (NPI)	<input type="radio"/> 2	<input checked="" type="radio"/> Mild pain=2	
<input type="radio"/> Wong Baker Faces Scales	<input type="radio"/> 3	<input type="radio"/> Mild pain=3	
<input type="radio"/> FLACC	<input type="radio"/> 4	<input type="radio"/> Moderate pain=4	
<input type="radio"/> NIPS	<input type="radio"/> 5	<input type="radio"/> Moderate pain=5	
	<input type="radio"/> 6	<input type="radio"/> Severe pain=6	
	<input type="radio"/> 7	<input type="radio"/> Severe pain=7	
	<input type="radio"/> 8	<input type="radio"/> Severe pain=8	
	<input type="radio"/> 9	<input type="radio"/> Severe pain=9	
	<input type="radio"/> 10	<input type="radio"/> Severe/worst possible=10	

Controlled Substance Policy Reminders

H
U
N
D
R
E
L
E
C
A
R
D

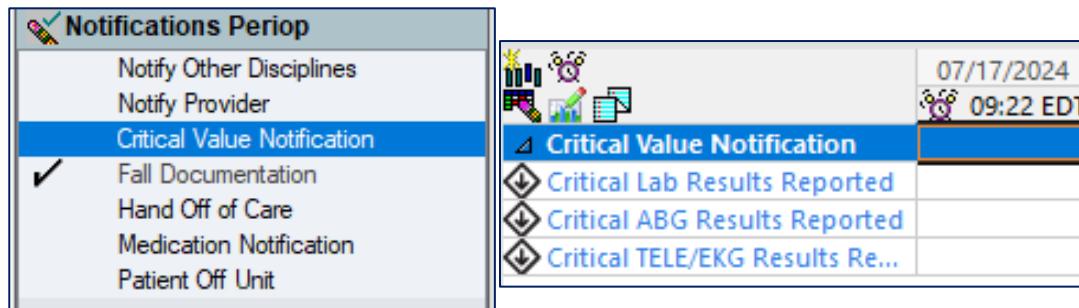
- ONLY pull medications for one patient at a time
- Medication must be administered, returned, or wasted immediately (within 30 minutes of removal from Pyxis).**
- Any controlled substance packaged in a larger amount than the dose being administered should be wasted and documented immediately (within 30 minutes from time of removal).
 - Waste is physically witnessed and documented by 2 authorized individuals
 - Both individuals must witness the waste. NEVER document a waste that you did not witness!
- Book bags, briefcases, duffel bags, purses or any other type of personal bag are to be left in lockers and not brought into a patient care area. If essential personal items are brought into a patient care area they must be always kept in a clear bag in plain view.

Refer to policy: COG.MM.001 Controlled Substance Monitoring

Critical Labs

Critical Lab Results: Labs that fall significantly outside the normal range and may indicate a life-threatening situation.

- Critical results require prompt notification to responsible caregiver
 - **Lab to Caregiver:** within 10 minutes (inpatient), within 30 minutes (outpatient) of result. ABG results are called immediately to appropriate caregiver.
- Caregiver receives result and performs read-back of critical value result to testing department
- Notify LIP/AP of critical value notification within required timeframe
 - **Caregiver to Provider:** notification within one hour of receipt
- Document LIP/AP notification in the medical record including name of provider notified and time of notification, as well as any orders received.

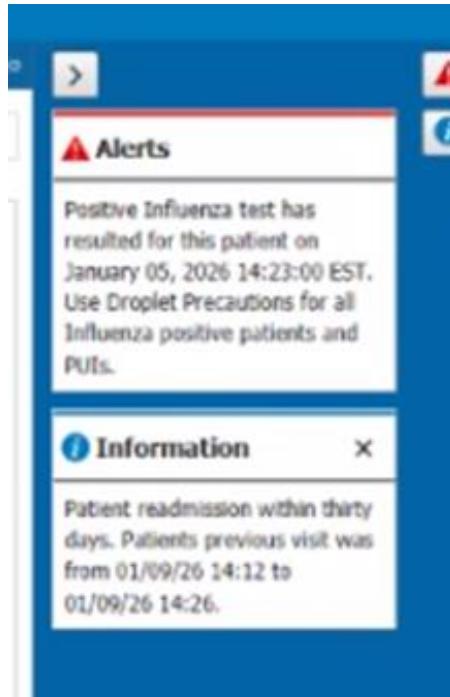


Policies: 1NPSG.ADM.0007 Critical Results Reporting and
1LAB.AD.0511.00 Critical Tests & Critical Value Reporting

 Clinical Updates

New Smart Zone Alerts for Positive Flu and Measles

- To promote patient and caregiver safety, a new Smart Zone alert will fire when a patient has a positive Flu or a Positive Measles result.



Critical Tests & Critical Value Reporting, 1LAB.AD.0511.00 Policy Update:

Go-Live 2/2/26

- Effective **February 2**, the critical low threshold for Hemoglobin is changing to **<7.0 g/dl** from **6.0 g/dl**.
- The new critical low threshold for Hemoglobin will be **< 7.0 g/dl**.

Reminder- Plastic Bedside Commode Buckets

- Please remember that the plastic commode buckets are single patient use, even when a liner is used.
- Do not reuse these buckets between patients. All body fluids should be removed, and these should be disposed of in the regular trash.

Pharmacy Update: Medication Product Changes

Go-Live 2/3/26

- The following medications will have product presentation changes.
 - Argatroban: Vial-2-Bag Adapter
 - Ketamine: Vial-2-Bag Adapter
 - Cefazolin: Mini-Bag Plus
 - Diltiazem: Mini-Bag Plus
 - Tranexamic acid: Premixed Bag

Current Product	New Product
Diltiazem 100 mg/100 mL AddVantage Bag (no longer manufactured)	Diltiazem 50 mg/10 mL vial + 50 mL NS minibag plus bag. New concentration: 50 mg/60 mL
Ketamine 200 mg/100 mL (compounded) Ketamine 500 mg/250 mL (compounded)	Ketamine 500 mg vial + 250 mL NS using V2B adapter
Cefazolin 3g/15 mL compounded syringe	Cefazolin 3g vial + 100 mL NS minibag plus
Argatroban 250 mg/250 mL compounded	Argatroban 250 mg/252.5 mL NS using V2B adapter

Mission Hospital: Regional Transport Services (RTS) Pick-Up Times for Discharged Patients

- **Scheduling:** Case Management schedules all RTS pickup times for home or outside facility discharges. The CM Checklist will be completed prior to scheduling transport.
- **Communication:** Nursing is responsible for notifying the patient and family of the scheduled time.
- **Patient Prep:** * Begin packing the patient 2 hours prior to pickup.
- Ensure the patient is fully ready to depart by the scheduled time.
- **Meds to Beds:** Requests must be completed and delivered before the RTS pickup.
 - Allow a 2-hour window for pharmacy delivery.
- **Facility Transfers:** Always include all physical prescriptions in the discharge packet for skilled nursing facilities.

Updated order comments for the following plans: Go-Live 2/2/26

- Sedation, Analgesia and Delirium Management for Critically Ill Patients Plan (System)
- FSER Pain, Agitation, and Delirium Management for Critically Ill Patients Plan
- Order comments are changing to be more specific with initial rates to all the drips that are reflective in Baxter pump libraries.

Medications

Continuous Sedation

Diprivan (Propofol) Drip 1000 mg/100 mL

100 mL, Routine, Max rate: 65 mcg/kg/min, Titrate by: see comments
Concentration 10 mg/mL: Following adequate pain control, if RASS remains greater than goal OR immediate sedation is required for acute agitation, begin infusion at 10 mcg/kg/min. If RASS goal not met in 3 mins, rebolus with 0.3 mg/kg IV over 1 min. Thereafter, nurse may bolus 0.3 mg/kg every 10 minutes PRN to achieve sedation goal.

Dexmedetomidine (Precedex) Drip 400 mcg/100 mL premix

Diprivan (Propofol) Drip 1000 mg/100 mL

Details:
100 mL, Routine, Max rate: 65 mcg/kg/min, Titrate by: see comments

Order Comment:
Concentration 10 mg/mL: Following adequate pain control, if RASS remains greater than goal OR immediate sedation is required for acute agitation, begin infusion at 10 mcg/kg/min. If RASS goal not met in 3 mins, rebolus with 0.3 mg/kg IV over 1 min. Thereafter, nurse may bolus 0.3 mg/kg every 10 minutes PRN to achieve sedation goal.

Intermittent Sedation

midazolam (Versed)

Intermittent Analgesia

fentaNYL

HYDROMorphone (Dilaudid)

Non Categorized

SubPhase Initiator (Pain, Agitation and Delirium Mana...

Increase infusion by 10 mcg/kg/min if patient requires 2 or more boluses in 1 hour.

ALWAYS WEAN SEDATIVE BEFORE ANALGESIC. If RASS is at or below goal decrease infusion by 10 mcg/kg/min q 1 hr.

For sedation holiday, see treatment algorithm.

Transition to Digital Blood Bank Documentation for the Operating Room-Effective Date: 2/2/26

- A transition to digital-only transfusion records is now in effect.
- Clinical workflows remain unchanged.
- Discontinuation of Paper Records: Standard transfusion records will no longer be delivered with blood units to the OR. All transfusion data is now integrated within the Electronic Health Record (EHR).
- Transfusion information is accessible through iView and the Blood Bank Summary Tab (see screenshots below).
- Exceptions for Paper Documentation During the initial implementation phase, paper copies will be issued only under the following circumstances:
 - Emergency Releases (e.g., MTP or Stat protocols).
 - Exceptional Instances identified by the Blood Bank during system stabilization.

The image contains three screenshots of the iView EHR interface, illustrating the transition to digital blood bank documentation.

- Screenshot 1: Blood Bank Summary**
This screenshot shows the "Blood Bank Workflow" tab within the "Blood Bank Summary" module. The "Blood Bank Transfusion" section displays a "Patient Overview" table with the following data:

	No confirmed blood type on record.
Blood Group	No antibodies on record.
Antibodies	No antigens on record.
Antigens	No current specimens available.
Specimen Availability	No transfusion requirements on record.
Transfusion Requirements	
- Screenshot 2: Blood Bank Summary**
This screenshot shows the "Blood Bank Workflow" tab within the "Blood Bank Summary" module. The "Labs-Floowsheet Grouping" section displays a table of blood bank studies:

	JAN 20, 2026...	JAN 20, 2026...	JAN 20, 2026...	JAN 20, 2026...	JAN 14, 2026...	JAN 09, 2026...	JAN 09, 2026...	JAN 06, 2026...													
Blood Type	---	---	---	---	O POS	---	---	---	---	---	---	---	---	---	---	---	---	---	O POS	Negative	Computer X...
Antibody Screen	---	---	---	---	Negative	---	---	---	---	---	---	---	---	---	---	---	---	---	O POS	Computer X...	Computer X...
Crossmatch Result	---	---	---	---	Computer X...	---	---	---	---	---	---	---	---	---	---	---	---	---	Computer X...	Computer X...	Computer X...
- Screenshot 3: Flowsheet**
This screenshot shows the "Flowsheet" tab within the "Flowsheet" module. The "Flowsheet" dropdown menu is set to "Transfusion Flowsheet". The "Procedure Selection" dropdown menu is set to "Procedure Selection".

Mission Hospital-Decedent Care Form Completion

The Decedent Care Form must be completed entirely as part of the Death Packet Completion.

- ❑ The Death Packet Consists of two forms: Decedent Care Form-3 pages (Mission Hospital) and the Handling and Transportation of Bodies Form.
- ❑ Follow instructions for each section carefully and fill out the forms completely.
- ❑ Decedent Care Form: **All sections** except “Authorization for Release of Body” **must be completed by patient’s nurse at time of death.**

DECEDENT CARE FORM PRINT LEGIBLY					
All sections except "Authorization for Release of Body" must be completed by patient's nurse at time of death. See please instruction list on page 2 for contacting Decedent Care, LifeShare, Minot Dispatch & Medical Examiner					
DECEDENT INFORMATION					
Decedent Name: Don, John	Date: 06-23-2005	Room Number: 1000	MRN: 000-00-0000		
Nursing Unit: A 1, 2, 3	Room: 313	Provider caring for patient at time of death: [John Smith, MD]			
ORGAN DONATION & PROCUREMENT					
LifeShare Carolina (LifeShare) must be notified within 1 hour for any ventilated patient with a life-threatening injury or illness, a GCS of 5 or less (regardless of sedation or paralytic), if death is imminent, if Brain Death testing is being considered/initiated, OR withdrawal of ventilator support is being considered.					
VENTILATED PATIENT					
Date Notified: 06-23-2005	Time Notified: 10:00 AM	Representative's Name: _____	Case ID #: _____		
Organ donation candidate? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Reason if no: _____				
LifeShare must be notified within 1 hour post-mortem.					
POST-MORTEM					
Date Notified: 06-23-2005	Time Notified: 10:00 AM	Representative's Name: John Smith	Case ID #: 000-00-1111436		
Death certificate issued? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Reason for No: After Recovery of Brain Death				
Eye donation candidate? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Reason for No: After Recovery of Brain Death				
Organ donation candidate? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Reason for No: After Recovery of Brain Death				
IV/HVS, select donation pathway: <input type="checkbox"/> After Brain Death <input checked="" type="checkbox"/> After Circulatory/Cardiac Death					
Body released to LifeShare for transfer to Funeral Home? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
MEDICAL EXAMINER (ME)					
If death meets any of the following criteria: Medical Examiner must be notified PRIOR to releasing the body from the unit. Medical Examiner must be notified of death due to the following causes and conditions, even though the patient may have survived for weeks, months or longer following injury:					
Medical Examiner Case Criteria:					
<ul style="list-style-type: none"> • Violence or trauma, including burns or drowning • Poisoning or overdose • Injuries or conditions including slip, trip or fall • Suicide or homicide • Occurring suddenly when the deceased had been in apparent good health or • When unattended by a physician • Occurring in a jail, prison, correctional institution or in police custody • Occurring in State facilities operated in accordance with Part 5 of Article 4 of Chapter 122C of the General Statutes; occurring pursuant to Article 19 of Chapter 15 of the General Statutes • Occurring under any suspicious, unusual or unnatural circumstance 					

DECEDENT CARE FORM PRINT LEGIBLY	
All sections except "Authorization for Release of Body" must be completed by patient's nurse at time of death.	
Decedent Name: <u>Doc. John</u>	Date: <u>06/27/2025</u>
MRN: <u>01-02-03-04</u>	
MEDICAL EXAMINER (M/E) (continued)	
If you are uncertain the death meets criteria, contact your M/E for guidance.	
Morts criteria for M/E case?	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, nurse must notify M/E	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, did M/E release body?	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
Autopsy requested by relatives?	
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, is consent form signed?	
FUNERAL HOME	
MOMC, MPAUC, LAD, Ped., PICU, NICU: Follow department procedures for release of body to funeral home or parent	
All other cases: Attempt to obtain information below, but DO NOT notify funeral home for transport.	
Funeral home chosen? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
Funeral Home notified? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
Name of Funeral Home: <u>Grace Funeral Home</u>	
Family member contact information: <input type="checkbox"/> UNKNOWN	
Name: <u>Linda A. Doe</u> Relationship: <u>Spouse</u>	
Phone: <u>325-123-4567</u> Address: <u>325 West Drive, Asheville, NC 28803</u>	
DISPOSITION OF DECEDENT BELONGINGS	
List all patient belongings, areas of death and other dispositions (Circle areas where necessary).	
Examples include: clothing, shoes, purse, wallet, glasses, hearing aids, and all other valuable.	
Note: Some belongings may be released to family members, while others remain with the body.	
Give to Family: (List all belongings in detail)	
ITEM	DESCRIPTION
Wallet	Brown Leather
Ring	Gold band with blue stone
Phone	Blue Case
Watch	Gold with black band
Received by (print): <u>Linda Doe</u>	
Received by (signature): <u>Signature - required</u>	
Witnessed by (print): <u>RN's Name</u>	
Witnessed by (signature): <u>Signature - required</u>	

DECEDENT CARE FORM <i>PRINT LEGIBLY</i>										
All sections except "Authorization for Release of Body" must be completed by patient's nurse at time of death.										
Decedent's Name: Doe, John	Date: 06-23-2014	MRN: DI-05-03-04								
DISPOSITION OF DECEDENT BELONGINGS (continued)										
Transferred with body: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; width: 25%;">ITEM</th> <th style="text-align: center; width: 25%;">DESCRIPTION</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">Decanter</td> <td style="text-align: center;">Upper & lower</td> </tr> <tr> <td style="text-align: center;">Hearing Aid</td> <td style="text-align: center;">Right ear</td> </tr> <tr> <td colspan="2" style="height: 40px;"></td> </tr> </tbody> </table>			ITEM	DESCRIPTION	Decanter	Upper & lower	Hearing Aid	Right ear		
ITEM	DESCRIPTION									
Decanter	Upper & lower									
Hearing Aid	Right ear									
Received by (print): JH-Ren's name	Received by (signature): Signature of Rec.									
Witnessed by (print): DC-Staff Member	Witnessed by (signature): Signature of Rec.									
VERIFICATION SIGNATURES										
By signing below, I verify that post-mortem process documentation has been reviewed.										
Signature of RN completing this document: Required	Date: 06/25/2015	Print: 1869								
Independent Verifier signature: Required	Date: 06/25/2015	Print: 1638								
*Nursing Unit Supervisor or House supervisor										
NOTIFICATION LIST										
Decedent Care Line: 828-213-0976 Mission Dispatch: 828-213-4133 Option 5 Lifeshare of the Carolinas: 800-932-4483 Medical Examiner On-Call: 										
(Notify for all in hospital death, 24 hours per day) (Notify for transport of body to Morgue) (Notify for all in hospital deaths within 1 hour post-mortem) (Notify for deaths meeting ME case criteria) See "AMON Physician Call Schedule" for on-call ME number										
DOCUMENTATION										
Patient's Nurse/Decedent Care Representative will provide copy of "Handling and Transportation of Bodies" & this "Decedent Care Form" to LifeShare, Medical Examiner or Patient's House as required for ongoing disposition of body. Completed signed originals of these documents will be forwarded to Health Information Management (HIM) to be added to decedent's medical record.										
AUTORIZATION FOR RELEASE OF BODY										
To be completed by Decedent Care Representative **AMOM, MFMU, L&D, Peds, PICU, NICU, Fellow procedure documents for release of body to funeral home or parent** Body of decedent, decedent's belongings (if any), a copy of "Handling and Transportation of Bodies", & this "Decedent Care Form" are released to funeral home listed on page 2.										
Funeral Home representative or parent signature: Completed by Funeral Home	Date: 06/25/2015	Print: 1266								
Decedent Care Form representative: Completed by Decedent Care Staff	Date: 06/25/2015	Print: 1790								



Updated: 7/9/25

CONFIDENTIAL – Contains proprietary information
Not intended for external distribution.

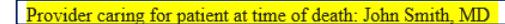
HCA Healthcare
Center for Clinical
Advancement
NC Division

Mission Hospital-Decedent Care Form Completion

H
U
D
L
E

C
A
R
D

Common Form Errors

- ❑ Provider Caring for the Patient at the Time of Death:
This section should list *the provider* that received notification of patient's death. The patient's nurse should not be listed in this section.

- ❑ LifeShare Case ID and Reasons given if not a donation candidate.
 - These sections are often left blank.
- ❑ “Disposition of Decedent Belongings” is a common section that is forgotten.
 - List ALL patient belongings at the time of death and their disposition in detail (Examples: clothing, shoes, purse, wallet, glasses, hearing aids and all other valuables)
- ❑ Use the Decedent Care Form Completion **Example** to ensure the form is accurately completed in its entirety

POST-MORTEM					
Date Notified:	0 6 / 2 5 / 2 0 2 5	Time Notified:	1 6 0 5	Representative's Name:	Susan
Tissue donation candidate?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Reason if no:	List Reason If Answer Is No	
Eye donation candidate?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Reason if no:	List Reason If Answer Is No	
Organ donation candidate?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Reason if no:	List Reason If Answer Is No	
If YES, select donation pathway:	<input type="checkbox"/> After Brain Death		<input type="checkbox"/> After Circulatory/Cardiac Death		
Body released by LifeShare for transfer to Funeral Home? <input type="checkbox"/> YES <input type="checkbox"/> NO					

Given to Family: (List all belongings in detail)	
ITEM	DESCRIPTION
Wallet	Brown Leather
Ring	Gold band with blue stone
Phone	Blue Case
Watch	Gold with black band

Received by (print): Linda Doe Received by (signature): Signature - required
Witnessed by (print): RN's Name Witnessed by (signature): Signature - required

DO NOT WRITE IN
MARGIN

DO NOT WRITE IN
MARGIN

DECEDENT CARE FORM

PRINT LEGIBLY

All sections except "Authorization for Release of Body" must be completed by patient's nurse at time of death.
See phone notification list on page 3 for contacting Decedent Care, LifeShare, Mission Dispatch & Medical Examiner

DECEDENT INFORMATION

Decedent Name: <u>Doe, John</u>	Date: <u>06-25-2025</u>	Time of Death: <u>1600</u>	MRN# <u>01-02-03-04</u>
Nursing Unit: <u>A 3 West</u>	Room# <u>A 3 3 8</u>	Provider caring for patient at time of death: <u>John Smith, MD</u>	

ORGAN DONATION & PROCUREMENT

LifeShare Carolinas (LifeShare) must be notified within 1-hour for: any ventilated patient with a life-threatening injury or illness, a GCS of 5 or less (regardless of sedation or paralytics), if death is imminent, if Brain Death testing is being considered/initiated, **OR** withdrawal of ventilator support is being considered.

VENTILATED PATIENT

Date Notified: _____ Time Notified: _____ Representative's Name: _____ Case ID # _____

Organ donation candidate? YES NO Reason if no: _____

LifeShare must be notified within 1-hour post-mortem.

POST-MORTEM

Date Notified: 06/25/2025 Time Notified: 1605 Representative's Name: Susan Case ID # 2025-123456

Tissue donation candidate? YES NO Reason if no: List Reason If Answer Is No

Eye donation candidate? YES NO Reason if no: List Reason If Answer Is No

Organ donation candidate? YES NO Reason if no: List Reason If Answer Is No

If YES, select donation pathway: After Brain Death After Circulatory/Cardiac Death

Body released by LifeShare for transfer to Funeral Home? YES NO

MEDICAL EXAMINER (ME)

If death meets any of the following criteria: Medical Examiner must be notified PRIOR to releasing the body from the unit.
Medical Examiner must be notified of deaths due to the following causes and conditions, even though the patient may have survived for weeks, months or longer following injury.

Medical Examiner Case Criteria:

- Violence or trauma; including burns or drowning
- Poisoning or overdose
- Injuries and accidents; including slip, trip or fall
- Suicide or homicide
- Occurring suddenly when the deceased had been in apparent good health or
- When unattended by a physician
- Occurring in a jail, prison, correctional institution or in police custody
- Occurring in State facilities operated in accordance with Part 5 of Article 4 of Chapter 122C of the General Statutes; occurring pursuant to Article 19 of Chapter 15 of the General Statutes
- Occurring under any suspicious, unusual or unnatural circumstance

DO NOT WRITE IN MARGIN



**Decedent Care
Form**

Page 1 of 3

MSJ-00001-231-1122



N0000-108

**PATIENT CHART
LABEL REQUIRED**

DECEDENT CARE FORM**PRINT LEGIBLY***All sections except "Authorization for Release of Body" must be completed by patient's nurse at time of death.*Decedent Name: Doe, JohnDate: 06/25/2025MRN: 01-02-03-04**MEDICAL EXAMINER (ME) (continued)**

If you are uncertain the death meets criteria, contact the ME for guidance.

Meets criteria for ME case? YES NOIf yes, nurse must notify ME. Time notified: 1600ME name: Sue SmithIf yes, did ME release body? YES NOAutopsy requested by relative? YES NOIf yes, is consent form signed? YES NO**FUNERAL HOME******MOMB, MFMU, L&D, Peds, PICU, NICU: Follow department procedures for release of body to funeral home or parent******All other units: Attempt to obtain information below, but DO NOT notify funeral home for transport.**Funeral Home chosen? YES NO**Funeral Home notified? YES NOName of Funeral Home: Groce Funeral HomeFamily member contact information: UNKNOWNName: Linda Doe Relationship: WifePhone: 828-123-4567 Address: 82 Wood Drive, Asheville, NC 28888**DISPOSITION OF DECEDENT BELONGINGS**

List all patient belongings at time of death and their disposition (Use separate sheet if necessary).

Examples include: clothing, shoes, purse, wallet, glasses, hearing aids, and all other valuables.

Note: Some belongings may be released to family members, while others remain with the body.

Given to Family: (List all belongings in detail)

ITEM	DESCRIPTION
Wallet	Brown Leather
Ring	Gold band with blue stone
Phone	Blue Case
Watch	Gold with black band

Received by (print): Linda DoeReceived by (signature): Signature - requiredWitnessed by (print): RN's NameWitnessed by (signature): Signature - required

DO NOT WRITE IN MARGIN

**Decedent Care
Form**

Page 2 of 3

MSJ-00001-231-1122



N0000-108

**PATIENT CHART
LABEL REQUIRED**

DECEDENT CARE FORM**PRINT LEGIBLY**

All sections except "Authorization for Release of Body" must be completed by patient's nurse at time of death.

Decedent Name: Doe, JohnDate: 06-25-2025MRN: 01-02-03-04**DISPOSITION OF DECEDENT BELONGINGS (continued)****Transferred with body:**

ITEM	DESCRIPTION
Dentures	Upper & lowers
Hearing Aids	Right Ear

Received by (print): FH Rep's nameReceived by (signature): Signature of Rep.Witnessed by (print): DCStaff MemberWitnessed by (signature): Signature of Rep.**VERIFICATION SIGNATURES**

By signing below, I verify that post-mortem process documentation has been reviewed.

Signature of RN completing this document: RequiredDate: 06/25/2025Time: 1609*Independent Verification signature: RequiredDate: 06/25/25Time: 1610

*Nursing Unit Supervisor or House supervisor

NOTIFICATION LIST

Decedent Care Line: 828-213-0976

(Notify for all in hospital deaths, 24 hours per day)

Mission Dispatch: 828-213-4133 Option 5

(Notify for transport of body to Morgue)

LifeShare of the Carolinas: 800-932-4483

(Notify for all in hospital deaths within 1-hour post-mortem)

Medical Examiner On-Call:

(Notify for deaths meeting ME case criteria)

See "AMION/Physician Call Schedules" for on-call ME number

DOCUMENTATION ROUTING

Patient's Nurse/Decedent Care Representative will provide a copy of "Handling and Transportation of Bodies" & this "Decedent Care Form" to LifeShare, Medical Examiner or Funeral Home as required for ongoing disposition of body.

Completed signed originals of these documents must be forwarded to Health Information Management (HIM) to be added to decedent's medical record.

AUTHORIZATION FOR RELEASE OF BODY

To be completed by Decedent Care Representative.

MOMB, MFMU, L&D, Peds, PICU, NICU: Follow department procedures for release of body to funeral home or parent

Body of decedent, decedent belongings (if any), a copy of "Handling and Transportation of Bodies", & this "Decedent Care Form" are released to funeral home listed on page 2.

Funeral Home representative (or parent) signature: Completed by Funeral Home Date: 06/25/2025 Time: 1700Decedent Care** representative signature: Completed by Decedent Care Staff Date: 06/25/2025 Time: 1700

DO NOT WRITE IN MARGIN



**Decedent Care
Form**



**PATIENT CHART
LABEL REQUIRED**