

NOT A PART OF PATIENT'S MEDICAL RECORD

WRTC Referral of Patient Death Worksheet
Call (703)641-0100 Within 60 Minutes of Asystole

Patient Sticker Area

Patient Information:

Last Name: _____ First: _____ Middle: _____

DOB: __/__/____ Age: __ Gender: _____ Height: _____ Weight: _____

MRN: _____ Race: _____ Admission Date-Time: __/__/____ __:__ am/pm

Time of Asystolic Death: Date and Time: __/__/____ at __:__ am/pm

Was the Patient Ever Ventilated? ___Yes ___No
If Ventilated: Was the Patient Terminally Weaned Off Ventilator? ___Yes ___No
___Patient died on the ventilator (currently ventilated)
___Patient was disconnected from vent less than 2 hours before death
___Patient was disconnected from vent more than 2 hours before death

Admission Diagnosis:

Clinical Course/Circumstances Surrounding Death:

Next of Kin (NOK) Information:

NOK Notified of Death: ___Yes ___No Onsite at Hospital: ___Yes ___No

NOK First Name: _____ and NOK Last Name: _____

Relationship: _____ Cell Phone: _____

Alternate phone: _____ Email: _____

Preliminary Screening Information:

Medical Examiner Case? ___Yes ___No

Please Circle if History of: HIV HBV HCV

Signs/symptoms of systemic infection? ___Yes ___No If Yes: _____

IV fluid given in the last hour? ___Yes ___No If Yes, What Amount: _____

Blood given in last 48 hours? ___Yes ___No If Yes, How Many Unit(s): _____

Any Positive Culture(s)?: ___Yes ___No ___Results Pending WBC: _____

If Yes, What Culture(s) Taken and Result: _____

Witnessed Arrest: ___Yes ___No Duration: _____minutes ROSC: ___Yes ___No

OR Last time seen or known alive: _____ Downtime (no CPR): _____minutes