Catholic Health

# DECEASED PATIENT NOTIFICATION

Administrative Documentation - SCAN, DECEASED PATIENT NOTICE, 3/26/25

**Requestor Information:**

Requestor's Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

**Deceased Patient (Decedent) Information:**

Decedent's Name: _____ Decedent's DOB: _____

Last Known Address: _____

Date of Death: _____

**I am requesting that the above named Decedent's medical record be reflected to show their death.**

**I am:** ☐ the spouse (no divorce or annulment of decree of separation) of the named deceased patient.

☐ the child (biological or legally adopted) of the deceased patient.

☐ the sibling (biolgical or legally adopted) of the deceased patient.

☐ the parent of the patient and the patient did not have a living spouse, child, grandchild or great- grandchild at the time of the patient's death.

☐ the exectutor of the estate of the deceased patient and have legal authority to act on their behalf.

☐ the distributee and have legal authority to act on their behalf.

**I understand that I must provide the following:**

- A certified copy of the Decedent's death certificate; and
- A copy of my (Requestor) government issued identification.

Requestor's Signature: _____

**This form, along with any required documentation, should be sent to the Catholic Health facility, entity or practice where the Decedent had last been seen (to the best of your knowledge).**

---

**FOR CATHOLIC HEALTH USE ONLY**

Date Request Received: _____ Facility/Entity Name: _____

MRN: _____