_____-_____ ☐ **DWD** ☐ **Illness**

Chronology and Death Certificate Extract Form

Date of birth: ___ / ___ / ___

First formal oral request for DWD (mm/dd/yr) ___ / ___ / ___

Second formal oral request for DWD (mm/dd/yr) ___ / ___ / ___

Written request from patient for DWD (mm/dd/yr) ___ / ___ / ___

Attending M.D. form signed (mm/dd/yr) ___ / ___ / ___

Consulting M.D. form signed (mm/dd/yr) ___ / ___ / ___

Prescription form completed (mm/dd/yr) ___ / ___ / ___

Psychiatric consultation form signed (mm/dd/yr) ___ / ___ / ___

Date of death: ___ / ___ / ___

Family Informed: ☐ 1 Yes ☐ 2 No ☐ 8 NA ☐ 9 NS

Attending DWD physician: # _____ _____ _____ _____ _____

Death Certificate Information

Physician who signed death certificate: # _____ _____ _____ _____ _____

Sex: ☐ ♂ ☐ 2 ♀

Decedent's Age _____

County of Residence: ☐ 03 ☐ 20 ☐ 24 ☐ 26 ☐ 34 ☐ ____

Marital Status: ☐ 1 Married ☐ 4 Legally Separated
☐ 2 Widowed ☐ 5 Divorced
☐ 3 Never Married ☐ 6 Unknown

Race: ☐ 1 White ☐ 4 Chinese ☐ 7 American Indian
☐ 2 Japanese ☐ 5 Other Asian ☐ 8 Hispanic
☐ 3 Vietnamese ☐ 6 Black ☐ 9 Unknown

Highest level of education:
☐ 1 8th grade or less
☐ 2 9th-12th grade, no diploma
☐ 3 High school graduate or GED
☐ 4 Some college, no degree
☐ 5 Associate degree
☐ 6 Bachelor's degree
☐ 7 Master's degree
☐ 8 Doctorate, etc. ☐ 9 Unknown

Occupation: _____

Underlying cause of death: _____

Death certificate/forms review done on ___ / ___ / ___ by ____ (initials)