HOSPICE GUIDELINES FOR REGISTERING AN ANTICIPATED HOSPICE DEATH IN GRUNDY COUNTY

1) The patient must live in Grundy County.
2) Complete the required Grundy County Hospice Registration form and submit it via fax (815-941-3355) or email (coroner601@grundyco.org) as soon as possible. These forms can be submitted 24 hours-a-day.
3) The doctor listed on the hospice registration form MUST be willing to sign the death certificate according to their diagnosis.
4) When death occurs, if during normal business hours (Mon-Fri 8:00 am-4:30 pm, call the office directly at (815) 942-3792. If death occurs outside of regular hours, please call the following: 1. John W. Callahan, Coroner (815) 405-1210
   2. Brandon Johnson, Deputy Chief Coroner (773) 573-0434
5) The representative from the coroner's office will ask for the time of death and the name of the funeral home that will be managing the arrangements. All of the information on the Grundy County Hospice form should be available for the nurse to relay to the Coroner at the time of notification. If the nurse feels there is anything suspicious or concerning, they should request the Coroner respond to the scene. The hospice nurse must have permission from the Coroner prior to releasing the body to the funeral home.
6) Please notify the Coroner's Office if your hospice patient expires outside of Grundy County (transported to a hospital, etc.) or if the patient is no longer receiving care through your hospice agency.
7) Please note at the time of death, the Grundy County Coroner maintains jurisdiction over the decedent and can facilitate any changes to protocol deemed necessary.
8) If you have any questions, please do not hesitate to contact our office at 815-942-3792.

Grundy County Coroner
John W. Callahan

GRUNDY COUNTY
HOSPICE
REGISTRATION

Patient Information:

Name of Patient: _____

Home Address/Facility Name: _____

Include City & Zip Code _____

Contact Phone Number: _____

Age: ____ Date of Birth: _____ SSN: _____

Next of Kin Information

Name: _____

Relationship to Patient: _____

Address: _____

Include City, State & Zip: _____

Contact Phone Number: _____

Medical Information: **Any recent falls or fractures? Yes No**

Diagnosis: _____

Physician: _____

Physician Contact #: _____

Funeral Home (if known): _____

Agency Information:

Hospice Agency: _____

Name of Reporting Person: _____

Agency Contact Number: _____