Report of Death

Vital Statistics 25 TAC Sec. 181.2(a) "The funeral director, or person acting as such, who assumes custody of a dead body or fetus shall obtain an electronically filed report of death through a Bureau of Vital Statistics system or complete a report of death before transporting the body. The report of death shall within 24 hours be mailed or otherwise transmitted to the local registrar of the district in which the death occurred or in which the body was found. A copy of the completed or electronically filed report of death as prescribed by the Bureau of Vital Statistics shall serve as authority to transport or bury the body or fetus within this state."

Print in dark ink the legal name of the deceased as shown on the Social Security card or birth certificate.

_____
first middle last suffix AKA maiden

Date of Death ____/____/_____ Sex _____ Date of Birth ____/____/_____
month day y ear month day year

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ ☐ None ☐ Not Available

Place of Death (check one)

☐Hospital Inpatient	☐Nursing home/Long term care facility
☐Hospital Emergency Room/Outpatient	☐Home of Deceased
☐Hospital Dead on Arrival	☐Other (specify):_____
☐Hospice Facility	
Facility Name (If not institution, give street & number)	
City, Town, or Precinct Number	County

Local registration office for the area where this death occurred: _____

☐ This death may be due to homicide, suicide or accident; or this death occurred without medical attendance.

Check One

This death will be certified by: ☐Physician ☐Medical Examiner ☐Justice of the Peace

Name and address of certifier:

Name and address of person making this report (if funeral director list license number and funeral home):

_____
Signature or electronic verification of person making this report Date of report

The Report of Death may be mailed, faxed, emailed, electronically registered or conveyed in person. A copy of this document is to accompany the body. This report contains confidential information.

Date /Time Received

Report	
Certificate	
Electronic	

Registrar Use Only

VS-115 Revised 9/2004 (may be duplicated)

WARNING: This is a governmental document. Texas Penal Code, Section 37.10, specifies penalties for making false entries or providing false information in this document.

FAX SHEET – CONSULAR NOTIFICATION

SUBJECT:

NOTIFICATION OF DEATH, SERIOUS INJURY OR ILLNESS OF A NATIONAL OF YOUR COUNTRY

DATE/TIME:_____

TO: Embassy/Consulate of _____ in _____, _____
(COUNTRY) (CITY) (STATE)

FROM:

Name/Office_____

Address_____

City _____ State_____ Zip Code_____

Telephone (_____) _____ Fax (_____) _____

The following individual, who we understand is a national of your country:

has died, was seriously injured, ***OR*** *is seriously ill within our jurisdiction.*
(CIRCLE ONE)

Name: _____

Date of Birth/Place of Birth: _____

Nationality/Country: _____

Passport Issuing Nation: _____

Passport Number: _____

Date of Death: _____ Place of Death: _____

Apparent Cause of Death: _____

For more information, **please call** _____ between the hours of _____.

Please refer to **case number** _____ when you call.

ADDITIONAL INFORMATION:

DISASTER SCENE DEATH INVESTIGATION RECORD

Date/Time: _____ Body Number: _____

Possible Name of Deceased: _____

Race: _____ Sex: _____ Approximate Age: _____ Photos Taken: Yes No

Physical Investigation

Clothing/Personal Effects: _____

Position and Location of Body: **(Grid location, GPS, etc./Note type of surface the body is on, covering, etc.)**

Rigor Mortis:	Livor:	Body Temperature:
Observations/Trauma: (NOTE MISSING PARTS)		Decomposition and Artifacts:
		Identifying Marks: (i.e. scars, tattoo, etc)

Comments/Summary: _____

Team Leader: _____

Recovery Team: _____

Recovery site report

Incident Name:						**Incident Location:**							
Prepared by (date/time/initials):						**Operational period** (date/times):							
Field Assigned Body ID Number			**Scene Information and Situation:**										
Description of Remains	(e.g., whole body, right arm, left foot, common tissue, etc.)												
	Sex	Male		Female		Unknown		**Condition:**	No Decomposition				
	Age	Infant	Child	Teen	Adult	Elderly	Unknown		Mild Decomposition				
	Race	White	Black	Asian	Hispanic/Latino		Unknown		Severe Decomposition				
Recovery Location Details:	**Date & Time Discovered:**					**Date & Time Recovered:**							
	Possible Name(s)												
	Street Address												
	GPS Coordinates												
	Grid #, if any												
	Other Details (e.g., name on medications or mail)												
Processing Performed on Recovery Scene	**GPS Photo**	Yes	No	**Non-GPS Photo**		Yes	No	**Other:**					
	Verichip Placed	Yes	No	**Verichip #:**									
	Remains Tagged	Yes	No	**Pouch Tagged**		Yes	No	**Tag #:**					
	Remains Delivered to Holding Morgue		Yes	No	**Transported Straight to Morgue**			Yes	No				

Recovery performed by:			
Agency:	Name:	Signature:	Date/Time:
Documentation and Photography performed by:			
Agency:	Name:	Signature:	Date/Time:
Transportation to Holding Morgue:			
Agency:	Name:	Signature:	Date/Time:
Holding Morgue Recipient:			
Agency:	Name:	Signature:	Date/Time:

Original on File with MFI Unit Copy with Decedent

RECOVERY SITE FIELD LOG

Incident Name:				Prepared by:		Operational Period (date/time):	
Received by:				Recovered by:		Recovery Location:	Description of Remains
Log #	Date & Time Received	Name & Initials of Recipient	Field Assigned Body ID #	Date & Time Recovered	Name & Initials of Recoverer	Description including grid, GPS coordinates, Verichip #, etc.	Condition recovered in
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							

TRANSPORTATION AND STORAGE MONITORING

Body Bag #	Vehicle Information					Destination	Released To	Driver License #
	Make	Model	Year	Lic Plate #	Color			

POST-PROCESSING STORAGE LOG

Incident Name:				**Prepared by:**			**Operational Period** (date/time):
Storage:					**Decedent Information**		
Log #	**Date & Time Stored**	**Name & Initials of Person Storing**	**Transferred to:** (Trailer #, Morgue, Interim, etc.)	**Location** (Marker, Grid, Rack number)	**Body ID Number**	**Name of Deceased** If unknown, leave room for name to be added	**Status of Remains** (Awaiting release, unidentified, no next of kin, reason held, etc.)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							

Storage Temperature Monitoring Log

Date: ________________					Storage Unit #: _______	
Temperature Check Reefers must be kept between 35-40°F Checks should occur every 6 Hours					**Defrost Cycle** Cycle should be run every 24 hrs	
	#1	#2	#3	#4	Time	
Time					Initials	
Initials						
Temperature	°F	°F	°F	°F		

Date: ________________					Storage Unit #: _______	
Temperature Check Reefers must be kept between 35-40°F Checks should occur every 6 Hours					**Defrost Cycle** Cycle should be run every 24 hrs	
	#1	#2	#3	#4	Time	
Time					Initials	
Initials						
Temperature	°F	°F	°F	°F		

Date: ________________					Storage Unit #: _______	
Temperature Check Reefers must be kept between 35-40°F Checks should occur every 6 Hours					**Defrost Cycle** Cycle should be run every 24 hrs	
	#1	#2	#3	#4	Time	
Time					Initials	
Initials						
Temperature	°F	°F	°F	°F		

Date: ________________					Storage Unit #: _______	
Temperature Check Reefers must be kept between 35-40°F Checks should occur every 6 Hours					**Defrost Cycle** Cycle should be run every 24 hrs	
	#1	#2	#3	#4	Time	
Time					Initials	
Initials						
Temperature	°F	°F	°F	°F		

IDENTIFCATION FORMS

DECEDENT IDENTIFICATION FORM

Incident Name:		**Prepared by** (date/time/initials):		**Photos attached:**	Yes	No
Body Id Number:		**Operational Period** (date/time):		**Fingerprints attached:**	Yes	No
Recovery Details:						

A. Physical Description						
A.1	**General Condition: A) (mark one) B)**	Complete body	Incomplete body (describe):		Body part (describe):	
		Well preserved	Decomposed	Mummified / Burned	Skeletonized:	Partially / Completely
A.2	**Apparent Sex (mark one and describe evidence):**	Male	Female	Probably Male	Probably Female	Undetermined
		Describe evidence (genitals, body hair, etc.):				
A.3	**Age Group (mark one):**	Infant	Child	Teenager	Adult	Elderly
A.4	**Physical Description (measure or mark one):**	Height (crown to heel):		Short	Average	Tall
		Weight (in pounds):		Slim	Average	Overweight
A.5	**A) Head Hair:**	Color:	Length:	Shape:	Baldness:	Other:
	B) Facial Hair:	None	Moustache	Beard or Goatee	Color:	Length:
	C) Body Hair:	Describe:				
A.6	**External Distinguishing Features**	Continue on additional sheets if needed. If possible, include a sketch of the main findings.				
	Ethnic group/skin color:			**Eye color:**		
	Physical (e.g. shape of ears, eyebrows, nose, chin, hands, feet, nails; deformities)					
	Implants (pacemaker, artificial hip, IUD, metal plates or screws, prosthesis etc.)					
	Past injuries/amputations (fractured bone, joint (e.g.; knee), any missing limbs or amputation; include location, side)					
	Dental Condition or Treatments: (missing teeth, gaps, crowns,, fillings, false teeth, etc.) Describe obvious features.					
	Other major medical conditions - evidence of operations, diseases, etc.					
	Skin marks (scars, tattoos, piercings, moles, birthmarks, etc.) Describe location and type.					

	Apparent injuries: include location, side.	

B. Personal Affects		
B.1	**Clothing** (Type of clothes, colors, fabrics, brand names, sizes, repairs) Describe in as much detail as possible all items.	
B.2	**Footwear** (Type, color, brand, size) Describe in as much detail as possible.	
B.3	**Eyewear** (Glasses (color, shape), contact lenses) Describe in as much detail as possible.	
B.4	**Habits** (Smoker (cigarettes, cigars, pipes), chewing tobacco, betel nut, alcohol, etc.) Please describe findings, including quantity.	
B.5	**Personal Items** (Watch, jewelry, wallet, keys, photographs, mobile phone (include number), medication. Cigarettes, etc.) Describe in as much detail as possible.	
B.6	**Identity documents:** (Identification card, driving license, credit card, video club cards, etc.) Take photocopy, if possible. Describe the information contained on the documents.	

C. Status of the Body									
C.1	**Identification verified or confirmed by:**	Drivers License:	State ID:	Passport:	Birth Certificate:	Other:			
		State:	State:	Country:	City/State:				
	Name & Date:	#:	#:	#:	#:				
C.2	**Disposition of Body:**	**Autopsy completed (if no, provide reason):**		Yes	No	**Death Certificate Signed**		Yes	No
		Storage:	Morgue	Refrigerated Container		Interim In-the-Ground	Other:		
		Signature:		**Name:**		**Date Time:**			
C.3	**Next of Kin:**	**Name:**		**Contact Information:**		**Notified by (date/time/initials):**			
		Relationship to deceased:							

Original on File with MFI Unit Copy with Decedent

MISSING PERSON IDENTIFICATION FORM

Incident Name:			**Prepared by** (date/time/initials):								
Operational Period	**Date/Time From:**					**Date/Time To:**					
Full Name of Missing Individual:											
Other Names (nicknames, maiden name, aliases etc):						**Sex**	Male		Female		
Age:		**Date of birth:**		**If exact age unknown, mark age group:**		Infant	Child	Teen	Adult	Elderly	
Personal Information	**Ethnic group:**				**Skin color:**						
	Birth City, State, Country:				**Birth hospital:**						
	Religious Preferences:				**Place of Worship:**						
	Education level:			**Last school attended:**							
	Marital Status:	Single	Engaged	Married	Widowed	Divorced	Separated	Unknown			
	Occupation:			**Employer Information** (Name, Address, Phone #):							
	Type of Business:										
	Ever been fingerprinted/foot printed:	Yes	No	Unknown	*Print location:*						
	Military Service:	Yes	No	Unknown	*Service #:*	*Aprrox. Service Dates:*					
		Branch:			*Country:*	*Military DNA Taken:*	Yes	No			
	Ever been arrested:	Yes	No	Unknown	*Arrested by:*						
	United States Citizen:	Yes	No	**Resident Alien Card:**	Yes	No	*Number:*				
	Immigration Status:			**Work Visa:**	Yes	No	*Number:*				
	List Memberships (Clubs, Fraternities, Sports, etc):										
Personal Items that may be with person, describe in as much detail as possible:	Watch	Necklace	Earrings	Rings	Bracelets	Other Jewelry:					
	Keys/Key Chain		Wallet	Purse	Cellular/Smart Phone	Music Player	Camera				
	Description/Other:										
Identifying habits:	Tobacco:	Chewing	Pipe	Cigarettes	Type:	Amount:					
	Recreational Drug user		Type:		Amount:	Other:					
	Description/Other:										
Skin markings, include quantity, location on the body, side of the body, along with any evidence of past	Scars		Moles/Birthmarks		Piercings		Tattoos				

skin markings (mark photos taken and provide location):	Yes- location: No	Yes- location: No	Yes- location: No	Yes- location: No

Height:			**If exact height unknown, mark estimate:**				Short			Average	Tall
Weight:			**If exact weight unknown, mark estimate:**				Slim			Average	Overweight
Eye color:	Blue	Brown	Green	Gray	Hazel	Black	Other:			Color/Description:	
Eyewear:	Contacts	Glasses	Implants	None	Description:						
Eye status:	Missing R	Missing L	Glass R	Glass L	Cataract	Vision Correction	Description:				
Hair Color:	Auburn	Brown	Gray	Salt & Pepper		Blonde	Black	Red	White	Other:	
Hair Length:	Bald	Shaved	Short < 3"	Medium	Long	Very Long	Male Pattern Baldness (describe):				
Hair Accessories:		Extensions	Hair pieces	Hair Transplant		Wig	Other (barrettes, clips, hair ties, etc.):				
Hair Description:		Thin	Average	Thick	**Texture:**	Curly	Wavy	Straight	N/A	Other:	
Facial hair:	Clean Shaven	Stubble	Lower Lip	Goatee	Moustache		Beard	Beard & Mustache		Sideburns	N/A
Facial hair color:		Brown	Gray	Salt & Pepper		Blonde	Black	Red	White	Other:	
Body hair:	*Describe - location, amount, color:*										
Fingernail Type:		Natural	Artificial	Unknown	**Fingernail length:**			Extremely long	Long	Medium	Short
Fingernail Color:					**Characteristics:**		Bitten	Decorated	Misshapen		Yellowed or Fungus
Toenail color:					**Characteristics:**		Bitten	Decorated	Misshapen		Yellowed or Fungus
Unique Physical Characteristics (i.e. shape of ears, nose, chin; any deformities or amputations; other special characteristics)											
Last Seen:	Alone	with an Individual	with a Group	Group Type and Members:							
	Last Location victim was seen (description, name, etc):										
Clothing last seen in or known to be wearing - describe in as much detail as possible (the type, colors, fabrics, sizes, brands, etc):											
Top		Bottom		Undergarments			Footwear		Outerwear/Accessories:		
Dentist	*Dentist:*			*Address:*							

Information	*Practice Name:*		*Phone #:*		*Email:*	
Dental Records Requested:	Yes	No	**Dental Records Obtained:**	Yes	No - reason:	Date of Records:
Dental Condition or Treatments, describe any obvious features (i.e. missing teeth, gaps, crowns, false teeth):						

Physician Information	*Physician:*			*Address:*				
	Practice Name:			*Phone #:*		*Email:*		
Physician Records Requested:		Yes	No	**Records Obtained:**	Yes	No - reason:	Date of Records:	
Diabetic:	Yes	No	Unknown	**If female, pregnancy in the past 12 months**		Yes - when:	No	Unknown
Current Medications (OTC or prescribed):								
Past injuries, include body location and side (amputations, bone fractures, etc.):								
Radiographs:	*Physician:*			*Type(s) of Radiograph:*				
	Location:			*Dates taken (if known):*				
Past Surgeries (type and date, if known):	Tracheotomy	Gall Bladder Removal		Caesarean	Reconstructive	Appendectomy	Laparotomy	Mastectomy
	Open heart	Tonsillectomy		Description/Other:				
Objects in body including body location and side:	Pacemaker	Bullets	Implants	Needles	Shrapnel	Artificial Joints	Metal Plates and/or Screws	
	Description/Other:							
Any additional important data or information:								

Item(s) with missing person's fingerprints:	Yes	No	**Item(s) potentially having samples of missing person's DNA:**	Yes	No
Photograph(s) of missing person attached:	Yes	No	**Primary Familial DNA Sample:**	Yes - Relation:	No
Individual(s) Providing Information:					

Contact Information for Potential Primary Familial DNA Donor:	*Full Name:*	*Address:*	*Sex:* M F
	Phone #1:	*Phone #2:* / *Email:*	*DOB:*

Relationship to Missing Person:	Mother	Father	Daughter	Son	Aunt	Uncle	Cousin	Grandmother	Grandfather

Contact Information for	*Full Name:*	*Address:*	*Sex:* M F

Potential Primary Familial DNA Donor:	*Phone #1:*		*Phone #2:*			*Email:*				*DOB:*
Relationship to Missing Person:	Mother		Father	Daughter	Son	Aunt	Uncle	Cousin	Grandmother	Grandfather
Contact Information for Potential Primary Familial DNA Donor:	*Full Name:*			*Address:*						*Sex:* M F
	Phone #1:		*Phone #2:*			*Email:*				*DOB:*
Relationship to Missing Person:	Mother		Father	Daughter	Son	Aunt	Uncle	Cousin	Grandmother	Grandfather

PERSONAL EFFECTS FORMS

Team Member Name: **Site Location:**

Item #	Date	GPS Coordinates	Category	Description (Material / Color / Size / Type / Brand	Comments / Condition

Category: (1) Clothing (2) Footwear (3) Jewelry (4) Watch (5) Glasses (6) Purse/Wallet (7) Currency (8) Electronics (9) Keys (10) Other

Chain of Custody

MRN or **Tracking #:**_____

Decedent's Name:_____

Decedent's DOB:_____Age:_____Sex:_____

Item#	Quantity	Description of Item

Relinquished By:	**Received By:**
Agency:_____	Agency:_____
Print:_____	Print:_____
Sign:_____	Sign:_____
Date:_____	Date:_____

Relinquished By:	**Received By:**
Agency:_____	Agency:_____
Print:_____	Print:_____
Sign:_____	Sign:_____
Date:_____	Date:_____

Personal Effects Release Form

Name of Decedent _____

Date _____ Time _____

Location _____

Name of Person Completing Form (print) _____

Signature _____ ***Date*** _____

List all personal effects being released to family; be as specific as possible (e.g. yellow metal ring with clear stone)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Name of person receiving personal effects _____

Relationship to decedent _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Alternate Phone Number _____

Signature (of person receiving property) _____Date _____

Witness (print) _____

Signature _____ Date _____

REMAINS RELEASE FORMS

Initial Notification Preference

Victim _____ Case number _____

FAC Interviewer _____ Date _____

Based on information received at the family interview, if/when the victim identification is made, the family:

- ☐ Does not wish to be notified.
- ☐ Wishes to be notified only one time when the first remains are identified
- ☐ Wishes to be notified each time remains are identified
- ☐ Wishes to be notified only after all known remains are identified
- ☐ Wishes to be notified through the following third party (specify i.e. clergy, funeral director, etc.)

  Name _____

  Address _____

  Telephone number(s) _____

Who to notify:

Name _____

Relationship to Deceased _____

Complete Address _____

_____

Telephone Number(s) _____

The family understands this information is tentative and will be formalized by a Remains Release Authorization *to be signed at time of notification.*

Remains Release Authorization

For _____ **(name of deceased)** **Case Number** _____

I/We the undersigned hereby authorize _____ (Name of ME/JP office)
to release the remains of _____(Name of Deceased)
to the designated Disaster Mortuary Team or other authorized agent.

I/We further authorize the designated Disaster Mortuary Team or another authorized agent to embalm and perform post mortem reconstructive surgery techniques, and otherwise prepare as they deem necessary and upon completion to release said remains to:

_____

_____

_____

Name, Address, and Phone Number of Funeral Home or Agent

In the event any additional tissues(s) are recovered in the future and are identified as belonging to the above name deceased, I/we request the following:

☐ I/We do not wish to be notified. I/We are authorizing the appropriate officials to dispose of said remains by methods deemed appropriate by said officials.

☐ I/We wish to be notified only one time when the first remains are identified

☐ I/We wish to be notified each time remains are identified

☐ I/We wish to be notified only after all known remains are identified

☐ I/We wish to be notified through a third party (specify i.e. clergy, funeral director, etc. – otherwise notifications will be made directly to signatory) _____

I/We certify that I/We have read and understand this document. I/We further state that I/We are or represent all of the next of kin and am/are legally authorized and/or charged with the responsibility of burial and/or final disposition of above said deceased.

Signed _____ Relationship to Deceased _____
Print Name _____ Date Signed _____ Time _____
Complete Address _____
Telephone Number(s) _____

Signed _____ Relationship to Deceased _____
Print Name _____ Date Signed _____ Time _____
Complete Address _____
Telephone Number(s) _____

Witness _____

Remains Release Authorization

Name of Deceased _____

Please be advised unidentified human tissue will be buried in an appropriate manner

In the event any additional tissue(s) are recovered in the future and are identified as belonging to the above names deceased. I/We request the following:

☐ I/We do not wish to be notified. I/We are authorizing the appropriate officials to dispose of said tissue(s) by methods deemed appropriate by said officials.

☐ I/We wish to be notified and will make a decision regarding disposition at that time. I/We the undersigned hereby authorize _____(Jurisdiction) to release the remains of _____(Name of Deceased) to the designated Disaster Mortuary Team or other authorized agent.

I/We further authorize the designated funeral home or another authorized agent to embalm and perform post mortem reconstructive surgery techniques, and otherwise prepare as they deem necessary and upon completion to release said remains to:

_____

_____

_____

(Name, address & phone of Funeral Home or Agent)

I/We certify that I/We have read and understand this document. I/We further state that I/We are all of the next of kin, or represent all of the next of kin and am/are legally authorized and/or charged with the responsibility of burial and/or final disposition of above said deceased.

Signed _____ Relationship to Deceased _____

Print Name _____ Date Signed _____ Time _____

Complete Address _____

Telephone Number(s) _____

Signed _____ Relationship to Deceased _____

Print Name _____ Date Signed _____ Time _____

Complete Address _____

Telephone Number(s) _____

Witness _____

Release of Human Remains

(1) **MRN-**_____

(2) Name of Deceased:_____

(3) Date of Release:_____

(4) Released To: _____
(Name of Person or Establishment)

(5) Address: _____

(6) Phone: _____

(7) I/We certify that I/We represent all of the next of kin of the above, and do hereby accept custody of said Human Remains.

Signed: _____ Date: _____ Time:_____

_____
(Print Name)

Signed: _____ Date: _____ Time: ____

_____
(Print Name)

(8) Witness: _____

_____
(Print Name)

(9) Released by: _____ Date: _____ Time: ____

_____

REMAINS RELEASED FOR FINAL DISPOSITION LOG

Incident Name:				**Prepared by:**	**Operational Period** (date/time):	
Released by:			**Decedent Information**		**Released to:**	
Log #	**Date & Time of Release**	**Name & Initials of Releaser**	**Body ID Number**	**Name of Deceased,** If unknown, leave room for name to be added	**Name of Funeral Home or Individual taking responsibility of remains**	**Date, Time, Name & Initials of Person picking up the remains**
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

Post-mortem Release Log

	Tracking Numbers			Victim Information		
	ME/JP Number	MRN Number	RM Number	Last Name	First Name	Middle Name
1						
	Release Information					
	Date	Time	Company Released To	License Plate #	Driver Name	Destination

	Tracking Numbers			Victim Information		
	ME/JP Number	MRN Number	RM Number	Last Name	First Name	Middle Name
2						
	Release Information					
	Date	Time	Company Released To	License Plate #	Driver Name	Destination

	Tracking Numbers			Victim Information		
	ME/JP Number	MRN Number	RM Number	Last Name	First Name	Middle Name
3						
	Release Information					
	Date	Time	Company Released To	License Plate #	Driver Name	Destination

	Tracking Numbers			Victim Information		
	ME/JP Number	MRN Number	RM Number	Last Name	First Name	Middle Name
4						
	Release Information					
	Date	Time	Company Released To	License Plate #	Driver Name	Destination

FAMILY ASSISTANCE FORMS

Family/Friend Registration Form

Use this form if no electronic/database registration system is available

Disaster Victim Information

Last Name _____ First Name _____ MI _____

For Multiple Disaster Victims of the Same Family, Use Additional Forms and Cross Reference with Victims Name at Bottom of this Page

1. Presenting Family Member/Friend Name

Last Name _____ First Name _____ MI _____

SS# (optional) _____ Relationship to Victim _____

Permanent Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Photo Identification Verification (type/#/State/County) _____

Medications/Medical Needs? ☐ Yes ☐ No

It Yes, Indicate Medication Needs _____

_____

Physician's Name _____ Physician's Phone # _____

Next of Kin to Disaster Victim? ☐ Yes ☐ No

If No, Name of Next of Kin _____

Notes _____

_____

_____

2. Presenting Family Member/Friend Name

Last Name _____ First Name _____ MI _____

SS# (optional) _____ Relationship to Victim _____

Permanent Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Photo Identification Verification (type/#/State/County) _____

Family/Friend Daily Sign-in Sheet

Use this form if a digital credentialing/ badging system is not available

Victim Name

Last Name _____ First Name _____ MI _____

Date	Time of Arrival	Family Member Name (please print)	Signature	Time of Departure

Instructions for Call Center Intake Calls: *Be patient. Be compassionate. Take your time but do not linger any more than necessary. Each phone line is very much needed. Do not make promises or guarantees, nor give out information on the status of any individual.* ***NOTE:*** *If the caller is in extreme distress – or they make any threats – get as much contact information as possible and immediately notify the Unit leader.*

For All Calls:

SCRIPT: **[Name of incident] call center. This is [your name]. How may I help you?**

ACTION: *(Wait for response. Then, if call is to)*

- ***Report Person(s) as Missing***

SCRIPT: ***Thank you very much for calling. May I please get some information?***

ACTION: *(Fill out intake form as completely as possible.)*

SCRIPT: ***You do not need to call 9-1-1. This information will be given to the group dealing with missing persons. Someone will be back in touch with you as soon as possible.***

- ***Inform that a Reported Missing Person is Found or a Self-Report***

SCRIPT: **Thank you very much for calling. May I please get some information?**

ACTION: *(Fill out intake form as completely as possible. Then,)*

SCRIPT: **We ask that you go to the Red Cross website at** www.safeandwell.org **and click on the "List myself safe and well" tab.**

ACTION: *(If self-reported mark "Self-Safe" as Reason for Call; if other reported mark "Found" as Reason for Call.)*

- ***Request Info on Missing Person(s)***

SCRIPT: **Our call center only gathers information. Law Enforcement and Search and Rescue Teams have direct access to it and are actively using this information to locate missing persons. We appreciate your concern but cannot give out information to anyone. We do recommend that you access the Red Cross' Safe and Well website** www.safeandwell.org **for any updates.**

ACTION: *(If the caller is in extreme distress – or they make any threats – get as much contact information as possible and immediately notify the Unit leader.)*

- ***Make a Donation or Volunteer to Help***

SCRIPT: **Thank you for your desire to help. Please access the [name of website] or call [phone number].**

Call Center Intake Form

Intake Information

Call Taken By _____

Date of Call _____ Time of Call _____

Caller Information

Name _____

Phone Number(s) _____ _____

Address _____

City _____ State _____ Zip _____

Missing Person Information

Person Calling About _____

Relationship to that Person _____

Are they the Primary Next of Kin? ☐ Yes ☐ No

If No, who is the next of Kin? _____

Where the Person Lives

Address _____

City _____ State _____ Zip _____

Phone Number(s) _____ _____

Where the Person Works

Address _____

City _____ State _____ Zip _____

Phone Number(s) _____ _____

Social Security Number _____

Why does the caller believe the Person was in/around the incident location?

_____

Missing person category (check one) ☐ **Known Missing** ☐ **Possible Missing** ☐**Not Known**

Other Information

Summarize _____

Follow-up with the Caller

Best time to reach them _____Phone number(s) _____ _____

Address for the next 24 hours _____

City _____ State _____ Zip _____Email_____

Follow-up needed/FAC staff responsible _____

_____

_____

Secondary Services Referral Form

Date: _____

Person completing form: _____

Referral # 1: *Indicate category of referral*

- ☐ Spiritual / Pastoral support
- ☐ Professional mental health services
- ☐ Substance abuse treatment
- ☐ Medical care
- ☐ Housing
- ☐ Financial
- ☐ Other disaster services: _____
- ☐ Other: _____

Referral contact information:

Name: _____

Phone (Business): _____ Phone (Cell): _____

Phone (Other): _____ Email: _____

Website: _____

Address: _____

_____

Referral # 2: *Indicate category of referral*

- ☐ Spiritual / Pastoral support
- ☐ Professional mental health services
- ☐ Substance abuse treatment
- ☐ Medical care
- ☐ Housing
- ☐ Financial
- ☐ Other disaster services: _____
- ☐ Other: _____

Referral contact information:

Name: _____

Phone (Business): _____ Phone (Cell): _____

Phone (Other): _____ Email: _____

Website: _____

Address: _____

_____

VICTIM ID FORMS

DNA COLLECTION FORMS

Family Reference Collection Form

Nuclear DNA Analysis

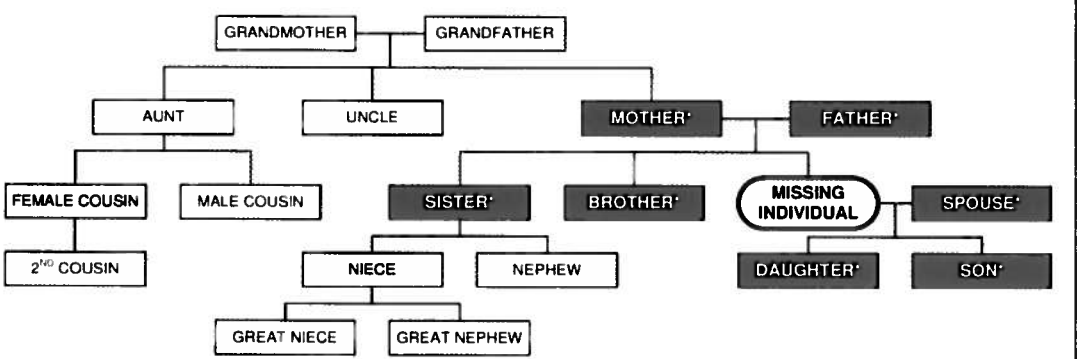
Case Number _____

DONOR INFORMATION			
LAST NAME	FIRST NAME	MIDDLE NAME	
SOCIAL SECURITY NUMBER (If Applicable)	HOME TELEPHONE		
HOME STREET ADDRESS			
CITY	STATE	ZIP	COUNTRY
DATE OF BIRTH (Month/Day/Year)			

FAMILY RELATIONSHIP

PLEASE CIRCLE YOUR KINSHIP TO THE MISSING INDIVIDUAL

* Primary Donor for a Nuclear Reference Sample (See list of Primary Donors on Page 2)



MISSING INDIVIDUAL INFORMATION		
LAST NAME	FIRST NAME	MIDDLE NAME
DATE OF BIRTH (Month/Day/Year)	DATE OF BIRTH (Month/Day/Year)	DATE OF BIRTH (Month/Day/Year)

DNA COLLECTION FORMS

Potential Living Biological Donors

Nuclear DNA Analysis

Case Number _____

MOTHER/FATHER OF MISSING INDIVIDUAL

NAME	AGE	ADDRESS	PHONE

BROTHERS AND/OR SISTERS OF MISSING INDIVIDUAL

NAME	AGE	ADDRESS	PHONE

SPOUSE OF MISSING INDIVIDUAL

NAME	AGE	ADDRESS	PHONE

CHILDREN OF MISSING INDIVIDUAL

NAME	AGE	ADDRESS	PHONE

PRIMARY DONOR FOR NUCLEAR ANALYSIS

An "appropriate family member" for nuclear DNA analysis is someone that is biologically related to and only one generation removed from the deceased. The following are family members who are appropriate donors to provide reference specimens, and in the order of the preference (family members are highlighted in **bold print** are the most desirable):

1. Natural (Biological) **Mother** and **Father**, OR

2. **Spouse** and Natural (Biological) **Children**, OR

3. A Natural (Biological) Mother or Father and victim's biological children, OR

4. Multiple Full Siblings of the Victim (i.e., children from the same Mother and Father)

DNA COLLECTION FORMS

Donor Consent Form

Nuclear DNA Analysis

Case Number _____

PRIVACY ACT STATEMENT / STATEMENT OF CONSENT

AUTHORITY:	(Determined by the agency collecting DNA sample)
PRINCIPLE PURPOSE(S):	Establish a DNA Reference Specimen Repository and Database of information from kindred family members or other individuals needing to be identified. DNA will be extracted from either vials of blood, dried blood and/or oral swabs, to be used in identifying remains.
ROUTINE USE(S):	None
DISCLOSURE:	Voluntary. Failure to provide reference sample or information may render DNA Identification impossible.

STATEMENT OF CONSENT

The above answers are correct to the best of my knowledge and belief, and I understand that my answers are important in determining my kindred family relationship to an unaccounted for service member or other unaccounted for individual. I have also read the privacy act statement above.

Realizing that nuclear or mitochondrial deoxyribonucleic acid (DNA) may be extracted from my blood and used in the identification of a kindred family member, I agree to donate my blood or other biological specimen, to have my DNA analyzed, if necessary, and to have my name and other relevant typing information placed in a confidential registry or database for identification and statistical analysis. I am voluntarily donating tubes of blood via venipuncture, or if impracticable, consent to the fingerstick method of securing a small amount of blood, or allowing the taking of an oral swab, if required.

I have not received a blood transfusion within the last three months. (If you have received a transfusion please wait for 90 days after the transfusion before providing the reference specimen.)

I consent to the _____ DNA laboratory using the information and specimens for the identification of any unaccounted for family member.

SIGNATURE	PRINT NAME	DATE

VERIFICTION OF DONOR IDENTIFICATION AND SPECIMEN COLLECTION

I have verified from a Photo-ID that the blood or other biological specimen collected has come from the above stated donor, and have confirmed the donor's name and / or social security number that is placed on the collection tubes.

SIGNATURE	PRINT NAME	DATE

Deceased Victim Record Cover Sheet

REQUEST DATE	RECEIVED DATE	Yes	No	Description	Record Source & Contact Information
				Family Interview Form	
				Medical X-rays	
				Medical Records	
				Dental X-rays	
				Dental Records	
				Fingerprint Records	
				Photographs	
				Other:	

Remarks / Notes

REQUESTED RECORDS LIST

Case Number: _____

Victim Name: _____
Last First Middle

Informant Name: _____
Last First Middle

Informant Address: _____

Informant Phone(s): _____

Location	*Contact*	*Phone*	*Date Ordered*	*Date Received*
Dental				
Fingerprints				
Radiographs				
Medical Records				
Photo Requests				
Notes				

VI. DMORT FORMS

RADIOGRAPH FINDINGS, HHS - 623

Purpose

The form provides a format for the documentation of significant radiographic findings to aid in victim identification at the emergency/disaster scene.

Preparation

The form is completed by the attending radiologist.

Distribution

The information on the form is retained as part of the permanent records and information is forwarded to the Information Resource Center.

VI. DMORT FORMS

RADIOGRAPH FINDINGS, HHS - 623

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	Significant findings	After examination of the above radiographs describe significant findings that may be instrumental with identification.
2	Signed	Signed by the radiologist doing the exam.
3	Date of Examination	Date of the exam mm/dd/yy.
4	MRN	List the assigned Morgue Reference Number

Radiograph Findings

(1) After examination of the above radiographs describe significant findings that may be instrumental with identification.

(2) Signed: _____ (3) Date of Examination: _____
Radiologist

(D-MORT 1998)

(4) MRN_____

VI. DMORT FORMS

EXTERNAL PREPARATION/EMBALMING CASE REPORT, HHS - 624

Purpose

Provides a non-contaminated record of the embalmer's recommendations and actions.

Preparation

This form is completed by the embalmer *after surgical gloves, gown etc have been removed.* Extreme care should be rendered to prevent contamination of the form with body fluids.

Distribution

A completed, non-contaminated form should be inserted into the respective DVP.

VI. DMORT FORMS

EXTERNAL PREPARATION/EMBALMING CASE REPORT, HHS - 624

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	Embalming Classification	Show viewable or non-viewable classification.
2	Name of Victim, Date, Time	Show the victims name, date mm/dd/yy, and time of the embalming (24-hour time).
3	Age, Sex, Race	Show the age, sex (M or F) and race of the victim.
4	Embalming Authorized By	Name of the person authorizing the embalming.
5	Was Autopsy Performed	Was autopsy performed, yes or no?.
6	Missing Body Structures	In the chart provided, color in the missing body structures.
7	Condition of Eyes	Describe the condition of eyes prior to embalming.
8	Condition of Facial Features	Describe the condition of facial features.
9	Beard	Was a beard or moustache present?
10	Teeth	General condition and presence of the teeth.
11	Method of Mouth Closure	Describe the method of mouth closure.
12	Arteries Injected	Identify and describe which arteries were injected
13	Veins	Identify the veins used for drainage.
14	Arterial Fluid	List the brand, name of arterial fluid, and dilution rate including volume.
15	Cavity Fluid	List the brand, name of cavity fluid and the volume injected.
16	Hypodermic Injection	List areas of hypodermic injection including the brand name of the fluid.
17	External Preservation	In general terms list technique used to perform external preservation.
18	Signature(S)	Sign and dated by embalmers performing procedure

External Preparation/Embalming Case Report

This form must be completed by the embalmer after surgical gloves, gown etc have been removed. Extreme care should be rendered to prevent contamination of the form with body fluids. A non-contaminated "Original" is to be inserted into the respective DVP. The contaminated form must be disposed of properly.

(1) Embalming Classification (as shown on DMORT Form 260): [ ] Viewable [ ] Non-Viewable

(2) Name of Victim:_____ Date of Prep: _____ Time: _____

(3) Age: ____ Sex : Male [ ] Female [ ] [ ] Other: _____ Race: _____

(4) Embalming Authorized by:

_____
(Print)

(5) Was Autopsy Performed: [ ] Yes [ ] No

(6)In the chart below color in, with black ink, ***only the missing*** *body structures.*

(7) Condition of Eyes prior to Embalming: (Describe):

_____

_____

(8) Condition of Facial Features: (Describe)

_____

_____

(9) Beard: [ ] Yes [ ] No Mustache: [ ] Yes [ ] No If there is **any** doubt whether to shave face then DO NOT SHAVE.

(10) Teeth: [ ] Natural [ ] Dentures [ ] Partial Plate [ ] No Teeth are Present [ ] Some Teeth are Present

(11) Method of Mouth Closure: [ ] Stainless Steel Implant (Injector Needle) [ ] Suture

(12) Arteries Injected:

_____

(13) Veins used for Drainage:

_____

(14) Brand & Name of Arterial Fluid: _____ Index: _____

Dilution Rate & Volume:

_____ ounces per 1st gallon
_____ ounces per 2nd gallon
_____ ounces per 3rd gallon
_____ ounces per 4th gallon
_____ ounces per 5th gallon
_____ ounces per _____gallon(s)

Potential Pressure Used: _____ lbs.
Actual Pressure Used: _____ lbs.

(15) Brand & Name of Cavity Fluid : _____ Index: _____
Volume Injected:

_____ ounces Thoracic cavity
_____ ounces Abdominal cavity

(16) Areas of Hypodermic Injection:
Brand & Name of Fluid: _____Index: _____
List areas of hypodermic injection:

_____

(17) External Preservation:
In general terms list technique used to perform external preservation:

(Use the back of the form to write additional information you feel should be noted).

(18) Signed: _____ Date: _____
(Embalmer)

_____
(Print Name)

Signed: _____
(Embalmer)

_____
(Print Name)

VI. DMORT FORMS

EMBALMING CLASSIFICATION OF HUMAN REMAINS, HHS - 625

Purpose

Provide a location for the viewable classification documentation of remains of the victim of the emergency scene.

Preparation

Prepared by the assigned embalmer(s)

Distribution

The completed form is inserted into the respective victim DVP.

VI. DMORT FORMS

EMBALMING CLASSIFICATION OF HUMAN REMAINS, HHS - 625

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	MRN	List the assigned Morgue Reference Number.
2	Date of Examination, Time	List the date mm/dd/yy and time (24-hour time).
3	Classification	List the certification of viewable remains in the opinion of the embalmers.
4	Classification	List the certification of non-viewable remains in the opinion of the embalmers.
5	Signature	Signature(s) of attending embalmers.

HHS - 625

Embalming Classification of Human Remains

(1) **MRN-**_____

(2) Date of Examination: _____ Time: _____

I/We have examined the above referenced human remains and have determined the following:

Classification:

(3) **[ ] Viewable**, In my/our opinion the probability is **good** to suggest that embalming and post mortem reconstructive surgery may allow viewing of the victim by family and/or friends. Therefore facial incisions, oral autopsy examination or extraction of fingers should not be performed unless deemed absolutely necessary for evidentiary value.

(4) **[ ] NON-Viewable**, In my/our opinion the probability is **poor** to suggest that embalming and post mortem reconstructive surgery may allow viewing of the victim by family and/or friends. Examinations may be accomplished as deemed necessary.

(5) Signed: _____ Signed: _____

_____ _____

Print Name Print Name

VI. DMORT FORMS

VICTIM EXTERNAL/AUTOPSY EXAMINATION, HHS - 626

Purpose

Provides a detailed format for the listing of property and physical characteristics of the victim.

Preparation

Prepared by the individual with the responsibility for the embalming and/or autopsy.

Distribution

Completed and made part of the permanent victim record

VI. DMORT FORMS

VICTIM EXTERNAL/AUTOPSY EXAMINATION, HHS - 626

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	MRN	List the assigned Morgue Reference Number for the case. Note this number is placed on each page of the 6 pages of this form.
2	Name of Examiner/Date	Print name of the examiner and examination date mm/dd/yy.
3	Items in Pockets	Include credit cards, driver's license, checks, cash, etc. Each item should be listed on a separate line.
4	Jewelry	Record jewelry as to anatomical location and give detailed description. All jewelry should be photographed.
5	Footwear	Show type, color, size, and material of the victim's footwear.
6	Outer Clothing	List outer clothing worn by the victim from the waist down.
7	Outer Clothing (waist up)	List outer clothing worn by the victim from the waist up.
8	Socks	List the under clothing from the waist down starting with socks.
9	Underwear	List the under clothing from the waist down including underwear.
10	Under Clothing (waist up)	List the under clothing from the waist up.
11	Physical Characteristics	List the victims physical characteristics including; length, weight race, eyes, etc.
12	Hair	List information about the victim's hair including body and facial hair, color, texture, etc.
13	Ears	List information about the victim's ears including piercing, lobes, etc.
14	Tattoos	List anatomical location and detailed description of tattoo(s) and photograph each.
15	Scars or Birthmarks Body Piercing	List anatomical location and detailed description of scars, birthmarks or body piercing.

VI. DMORT FORMS

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
16	Fingernails	List information about the victim's fingernails including length and polish.
17	Toenails	List information about the victim's toenails including length and polish.
18	Missing Body Structures	List information about any missing body structures from the victim.
19	Obvious Prosthesis or Implants	List any obvious prosthesis or implants from the victim.
20	Disease or Conditions	List any external evidence of disease or conditions.
21	Trauma	List any trauma to the head. This section may be dictated as part of the Autopsy Report.
21a	Chest	List any trauma to the head. This section may be dictated as part of the Autopsy Report.
21b	Upper Extremities	List any trauma to the upper extremities. This section may be dictated as part of the Autopsy Report.
21c	Lower Extremities	List any trauma to the lower extremities. This section may be dictated as part of the Autopsy Report.
21d	Back	List any trauma to the back. This section may be dictated as part of the Autopsy Report.
22	Autopsy Examination	The Autopsy may be dictated and transcribed.

Victim External/Autopsy Examination

(1) **MRN**_____

(2) Print Name of Examiner:_____Date:_____

Items in Pockets, Jewelry and Clothing

(List in detail, size, color, material, brand, manufacturer, unique characteristics, photograph if there is something unique)

Additional information may be written on back of page, if so make reference to line number

Record Jewelry as to anatomical location and give detailed description. All jewelry should be photographed with body reference number in photo. Body piercing should be identified in detail.

(3) **Items in Pockets:** **(Credit cards, drivers license, checks. cash ound on victim should be photocopied or itemized in more detail on D-Mort Form 280. Otherwise list items below.**

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

(4) **Jewelry:**

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

MRN: _____

HHS - 626

Victim External/Autopsy Examination

(5) **Footwear:** Type Material Color Size Manufacturer

13.Left Foot _____

14.Right Foot _____

(6) **Outer Clothing (waist down)**

15. _____

16. _____

17. _____

(7) **Outer Clothing (waist up)**

18. _____

19. _____

20. _____

Under Clothing (waist down)

(8) **Socks:**

21. Left Foot _____

22.Right Foot _____

(9) **Underwear**

23. _____

24. _____

MRN:_____

HHS - 626

Victim External/Autopsy Examination

(10) **Under Clothing (waist up)**

25. _____

26. _____

27. _____

(11) **Physical Characteristics**

28. Race: _____ 28a. Length:_____ 28b. Appx. Weight: _____

29. Build : [ ] Small [ ] Medium [ ] Large

30. Eye Color:_____

(12) **Hair :** (Hair, beard and mustache samples should be collected and placed in separate containers)

31. Head hair: [ ] Own Hair [ ] Wig [ ] Toupee

32. Head hair Color _____ 32a. Head hair Length:_____

33. Head : [ ] Bald [ ]Partial Bald

34. Facial Hair: [ ]Beard, if so Length: [ ] Long [ ] Short Color:_____

35. [ ]Mustache if so Style:_____ Color_____

36. Eyebrows: [ ]Long [ ]Short [ ]None Color:_____

(13) **Ears:**

37. Ear lobes are (Refer to diagram on back of page) [ ]Attached [ ]Unattached

38. Lobes pierced: [ ]NO, if yes, [ ]Left # of holes____ [ ]Right # of holes___

39. Helix pierced: [ ]No, if yes, [ ]Left # of holes____[ ]Right # of holes_____

MRN: _____

HHS - 626

Victim External/Autopsy Examination

(14) **Tattoos:**
(List anatomical location and detailed description of tattoo(s) and photograph each)

40. _____

41. _____

42. _____

43. _____

(15) **Scars or Birthmarks Body Piercing:**
(List anatomical location and detailed description)

44. _____

45. _____

46. _____

47. _____

(16) **Fingernails:**

48. Left Hand: [ ]Long [ ]Short [ ]Polished, if yes, Color ____

49. Right Hand [ ]Long [ ]Short [ ]Polished, if yes, Color ____

(17) **Toenails:**

50. Left Foot: [ ]Long [ ]Short [ ]Polished, if yes, Color ____

51. Right Foot [ ]Long [ ]Short [ ]Polished, if yes, Color ____

(18) **Missing Body Structures:**

52._____

53. _____

54. _____

MRN: _____

HHS - 626

Victim External/Autopsy Examination

(19) Obvious Prosthesis or Implants:
(List anatomical location and description)

55. _____

56. _____

57. _____

58. _____

(20) External Evidence of Disease or Condition:
59. _____

60. _____

61. _____

62. _____

(21) Trauma:
(This section may be dictated as part of the Autopsy report)

Head:

63. _____

64. _____

65. _____

66. _____

(21a) **Chest:**

67. _____

68. _____

69. _____

70. _____

MRN: _____ HHS - 626

Victim External/Autopsy Examination

(21b) **Upper Extremities:**

71. _____

72. _____

73. _____

74. _____

(21c) **Lower Extremities:**

75. _____

76. _____

77. _____

78. _____

(21d) **Back:**

79. _____

80. _____

81. _____

82. _____

(22) **Autopsy Examination**

May be dictated and transcribed.

DMORT policy requires DNA samples to be collected on each case unless the "disaster specific" pathology plan overrules this policy.

VI. DMORT FORMS

ITEMIZED LISTING PERSONAL EFFECTS DISCOVERED ON VICTIM, HHS - 627

Purpose

Provide a format for listing specific personal effects found on or with a victim. The form also provides a chain of transfer custody of these items.

Preparation

The Personal Effects Unit Leader completes the form prior to any autopsy.

Distribution

The record of property and transfer remains in the victim's file maintained at the scene of the incident.

VI. DMORT FORMS

ITEMIZED LISTING PERSONAL EFFECTS DISCOVERED ON VICTIM, HHS - 627

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	MRN	List the assigned Morgue Reference number.
2	Item Description	List a detailed item description, by line, of all items discovered on the victim.
3	Release/Transfer of Custody	Release or transfer of custody of the items logged in on the form belonging to the victim. Each person transferring property must sign for the receipt of this property.

HHS - 627

Itemized Listing
Personal Effects Discovered on Victim

(1) **MRN-**_____

(2) Item Description:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

Additional Items should be listed on another DMORT Form # 280 Items such as Credit cards, store charge cards, drivers license, identification cards, checks, lottery tickets or important documents should be photocopied on the back of this form or a photocopy attached to this form.

(3) Release/Transfer Of Custody:

Transfer 1. Received from: _____ Section # _____

I, _____ hereby acknowledge receipt of the above mentioned item(s) and accept full responsibility of custody.

Signed:_____Date:_____Time:_____

Transfer 2. Received from: _____ Section # _____

I, _____hereby acknowledge receipt of the above mention item(s) and accept full responsibility of custody.

Signed: _____Date: _____ Time:_____

Transfer 3. Received from: _____ Section # _____

I, _____hereby acknowledge receipt of the above-mentioned item(s) and accept full responsibility of custody.

Signed: _____ Date: _____ Time: _____

VI. DMORT FORMS

RELEASE OF HUMAN REMAINS, HHS - 628

Purpose

The form provides written documentation for verification and approval for the release of victim's remains.

Preparation

The Personal Effects Unit Leader prepares the form.

Distribution

The form becomes a part of the official record of the victim of the incident.

VI. DMORT FORMS

RELEASE OF HUMAN REMAINS, HHS - 628

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	MRN	List the assigned Morgue Reference Number.
2	Name of Deceased	List the full name including last name, first name and middle name.
3	Date of Release	List the date of release of the victim.
4	Released To	List the name of person or establishment released to.
5	Address	List the address of person or establishment released to.
6	Phone	List the telephone number of person or establishment released to.
7	Certification and Signature	Certification that the signature is accepting custody of the victims remains.
8	Witness	Printed name and signature of witness.
9	Released by	Name of the person making the release of the remains.

Release of Human Remains

(1) **MRN-**_____

(2) Name of Deceased:_____

(3) Date of Release:_____

(4) Released To: _____
(Name of Person or Establishment)

(5) Address: _____

(6) Phone: _____

(7) I/We certify that I/We represent all of the next of kin of the above, and do hereby accept custody of said Human Remains.

Signed: _____ Date: _____ Time:_____

_____
(Print Name)

Signed: _____ Date: _____ Time: ____

_____
(Print Name)

(8) Witness: _____

_____
(Print Name)

(9) Released by: _____ Date: _____ Time: ____

_____
(Print Name)

VI. DMORT FORMS

CHAIN OF CUSTODY, HHS - 629

Purpose

Provides written receipts and documentation of specific property items and transfer of this property from one person to another.

Preparation

The form is prepared by anyone having or documenting victim property custody.

Distribution

The form stays with the property until it is used as a transfer document from one person to another.

VI. DMORT FORMS

CHAIN OF CUSTODY, HHS - 629

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	MRN	List the assigned Morgue Reference Number.
2	Item Description	List a complete, accurate description of the item.
3	Transfer Information	List the name of the person transferring the item and the signature and name of the person receiving the item listed.

HHS - 629

Chain of Custody

(1) **MRN:** _____

(2) Item Description:

_____

(3) **Transfer 1.**Received from: _____ Section #_____

I, _____hereby acknowledge receipt of the above mentioned item(s) and accept full responsibility of custody.

Signed:_____ Date: _____ Time: _____

Transfer 2. Received from; _____ Section # _____

I, _____hereby acknowledge receipt of the above mentioned item(s) and accept full responsibility of custody.

Signed: _____ Date: _____ Time: _____

Transfer 3. Received from: _____ Section # _____

I, _____hereby acknowledge receipt of the above mentioned item(s) and accept full responsibility of custody.

Signed: _____ Date: _____ Time: _____

Transfer 4. Received from: _____ Section # _____

I, _____hereby acknowledge receipt of the above mentioned item(s) and accept full responsibility of custody.

Signed: _____ Date: _____ Time: _____

Transfer 5. Received from: _____ Section # _____

I, _____hereby acknowledge receipt of the above mentioned item(s) and accept full responsibility of custody.

Signed: _____ Date: _____ Time: _____

VI. DMORT FORMS

VICTIM RECORDS/INFORMATION STATUS REPORT, HHS - 630

Purpose

Provides a receipt and documentation of requests for various victim records.

Preparation

Prepared by the person making the request for information regarding the victim.

Distribution

The request and documentation stays with information on the victim during the incident.

VI. DMORT FORMS

VICTIM RECORDS/INFORMATION STATUS REPORT, HHS - 630

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	Name of Victim	List the full name of the victim.
2	MRN	List the assigned Morgue Reference Number.
3	Record Item	Description of record(s) requested.
4	Contact person of sender	Contact person of sender, including telephone number.
5	Date requested	Include mm/dd/yy.
6	Estimated arrival at ID center	Estimated date of arrival at the Information Resource Center.
7	Records delivered by	How records will be delivered.
8	Sender contact	Provides a listing to identify that the sender was contacted by name and contact number.

HHS - 630

Victim Records/Information Status Report

(1) Name of Victim: _____(2) MRN-_____

(3) Record Item 1._____
(Description of Record(s))

The above record(s) have been requested from:

_____

(4) Contact person of sender: _____Phone: _____

(5) Date requested: _____

(6) Estimated date of arrival at ID center: _____

(7) Record(s) will be delivered via: [ ] FEDEX [ ] FAX [ ] USMAIL [ ] UPS

(8) Sender was contacted by:

_____

_____

Record Item 2.

_____
(Description of Record(s))

The above record(s) have been requested from:

_____

Contact person of sender: _____Phone: _____

Date requested: _____

Estimated date of arrival at ID center: _____

Record(s) will be delivered via: [ ] FEDEX [ ] FAX [ ] USMAIL [ ] UPS

Sender was contacted by:

_____

_____

VI. DMORT FORMS

SAMPLE/ LETTER, HHS - 631

Official Notification to Next of Kin
Regarding Positive Identification of Victim

Purpose

The form provides a suggested format, which should be created on the official letterhead of the local Medical Examiner/Coroner.

Preparation

The Medical Examiner/Coroner or designee writes the letter.

Distribution

The original letter is mailed to the next of kin with a copy maintained in the victim's file on the incident.

VI. DMORT FORMS

SAMPLE/ LETTER, HHS - 631
Official Notification to Next of Kin
Regarding Positive Identification of Victim

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	Date	List the date of the letter mm/dd/yy.
2	Name of Next of Kin	Name of next of kin.
3	Address	Provide a complete address of the next of kin.
4	Salutation	Dear "next of kin"
5	Note	Attach to this letter to HHS - 632 "Release Authorization" if remains are classified as "Incomplete Human Remains" INC/HR or HHS - 633 "Release Authorization" if the remains is classified as "Complete Human Remains" C/HR.

SAMPLE/ LETTER

Official Notification to Next of Kin
Regarding Positive Identification of Victim

(The following is a suggested format which should be created on the official letterhead of the Office Medical Examiner/Coroner of jurisdiction)

(1) Date

(2) Name of Next of Kin

(3) Address

(4) Dear, ...

Please consider this letter official notification to you and your family that the body of your _____has been positively identified. Identification
enter relationship, enter full name of deceased
was accomplished as a result of forensic examinations correlated with ante-mortem records. On behalf of myself and the entire mortuary disaster team please accept our heartfelt condolences regarding the loss of your loved one.

I appreciate your patience and cooperation during this most trying time. It is necessary for you and your family to make certain decisions regarding disposition. Please carefully read the following information and complete where necessary.

Our office will arrange for your _____to be transferred to a funeral
enter relationship
home or agent of your designation. Please sign and return the attached RELEASE FORM to the official who delivered this form to you.

Sincerely,

Name of Medical Examiner/Coroner or designee

(5) NOTE:
(Attach to this letter HHS - 632 "Release Authorization" if remains is classified as "Incomplete Human Remains" INC/HR or HHS - 6333"Release Authorization" if the remains is classified as "Complete Human Remains" C/HR.)

VI. DMORT FORMS

RELEASE AUTHORIZATION (INC/HR), HHS - 632

Purpose

This form provides a formal release from the next of kin to a victim for the release of Incomplete Human Remains" INC/HR. This form is to be used in other than transportation disasters.

Preparation

The assigned medical examiner or designee initiates the form.

Distribution

A copy of the form is retained in the incident victim folder at the incident site.

VI. DMORT FORMS

RELEASE AUTHORIZATION (INC/HR), HHS - 632

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	Name of Deceased	List the full name of the deceased.
2	MRN	List the assigned Morgue Reference Number.
3	Additional Tissue(s) Recovery	Provides a yes and no box for disposition of added tissue recovery.
4	Authorized by	List the name of the Medical Examiner/Coroner or designee.
5	Remains of	List the name of the deceased.
6	Authorize embalming	Release for permission for DMORT to conduct embalming.
7	Release of remains	Name and address of post embalming remains release.
8	Next of Kin certification	Certification of next of kin including name, address, telephone, relationship, etc.

HHS - 632

Release Authorization (INC/HR)

*(This form is to be used in **Other Than** Transportation Disasters)*

(1) Name of Deceased: _____

(2) MRN-_____
Please be advised unidentified human tissue will be buried in an appropriate manner.

(3) In the event any additional tissue(s) are recovered in the future and are identified as belonging to the above named deceased. I/We request the following:
1. [ ] I/We **do not** wish to be notified. I/We are authorizing the appropriate officials to dispose of said tissue(s) by methods deemed appropriate by said officials.

2. [ ] I/We **wish to be** notified and will make a decision regarding disposition at that time.

(4) I/We the undersigned hereby authorize the _____Office to release the
(Name of ME/Coroner)

(5) remains of : _____to the designated Disaster Mortuary Team.
(Name of Deceased)

(6) I/We further authorize the designated Disaster Mortuary Team to embalm, and perform post mortem reconstructive surgery techniques, and otherwise prepare, as they deem necessary and

(7) upon completion to release said remains to:

_____
(Name, address & phone of Funeral Home or Agent)

(8) I/We certify that I/We have read and understand this RELEASE AUTHORIZATION. I/We further state that I/We are all of the next of kin, or represent all of the next of kin and am/are legally authorized, and/or charged with the responsibility of burial and/or final disposition of above said deceased.

Signed: _____ Relationship to Deceased:_____

Print Name; _____ Date Signed: _____ Time: _____

Complete Address:_____
_____

Phone: _____

Witness:_____

Print Witness Name:_____

VI. DMORT FORMS

RELEASE AUTHORIZATION (C/HR), HHS - 633

Purpose

This form provides a formal release from the next of kin to a victim for the release of Complete Human Remains" INC/HR. This form is to be used in other than transportation disasters.

Preparation

The assigned medical examiner or designee initiates the form.

Distribution

A copy of the form is retained in the incident victim folder at the incident site.

VI. DMORT FORMS

RELEASE AUTHORIZATION (C/HR), HHS - 633

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	Name of Deceased	List the full name of the deceased.
2	MRN	List the assigned Morgue Reference Number.
3	Additional Tissue(s) Recovery	Provides a yes and no box for disposition of added tissue recovery.
4	Me/Coroner authorization	List the name of the Medical Examiner/Coroner or Designee.
5	DMORT authorization	List the name of the deceased.
6	Signature	List the signature and relationship to the deceased.
7	Print Name	Print the name of the person signing in 6 above. Include date mm/dd/yy and 24-hour time.
8	Complete Address	List the complete address including street name and number, city, state and zip code of the person signing in 6 above.
9	Phone	List the phone number (including the area code) of the individual signing item 6 above.
10	Signed	List the signature and relationship to the deceased.
11	Print Name	Print the name of the person signing in 10 above. Include date mm/dd/yy and 24-hour time.
12	Complete address	List the complete address including street name and number, city, state and zip code of the person signing in 10 above.
13	Phone	List the phone number (including the area code) of the individual signing item 10 above.
14	Witness	Show the witness signature
15	Print Witness Name	Print the name of the witness signing in number 14 above. Include first name, middle initial, and last name.

Release Authorization (C/HR)

*(This form is to be used in **Other Than** Transportation Disasters)*

(1) Name of Deceased:_____

(2) MRN-_____

(3) I/We the undersigned hereby authorize the _____Office to release the
(Name of ME/Coroner)
remains of : _____to the designated Disaster Mortuary Team.
(Name of Deceased)

(4) I/We further authorize the designated Disaster Mortuary Team to embalm, and perform post mortem reconstructive surgery techniques, and otherwise prepare, as they deem necessary and upon completion to release said remains to:

_____
(Name, address & phone of Funeral Home or Agent)

(5) I/We certify that I/We have read and understand this RELEASE AUTHORIZATION. I/We further state that I/We are all of the next of kin, or represent all of the next of kin and am/are legally authorized, and/or charged with the responsibility of burial and/or final disposition of above said deceased.

(6) Signed: _____ Relationship to Deceased:_____

(7) Print Name; _____ Date Signed: _____ Time: _____

(8) Complete Address:
_____

(9) Phone: _____

(10) Signed: _____Relationship to Deceased: _____

(11) Print Name: _____Date Signed: _____ Time: _____

(12) Complete Address:
_____
_____

(13) Phone: _____

(14) Witness:_____

(15) Print Witness Name:_____

VI. DMORT FORMS

DECLARATION OF POSITIVE IDENTIFICATION OF DISASTER VICTIM, HHS - 634

Purpose

This form provides a format to positively declare the identification of a disaster or incident victim.

Preparation

The form is prepared in consultation with Medical Examine/Coroner assigned to the team.

Distribution

The completed form becomes part of the permanent record of DMORT identification activities.

VI. DMORT FORMS

DECLARATION OF POSITIVE IDENTIFICATION OF DISASTER VICTIM, HHS - 634

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	MRN	Enter assigned Morgue_Reference Number.
2	Name of Victim	Names of victim, including first name, middle initial, last name, sex ,and race.
3	Point of Ante Mortem Data	List the specific points of collection and correlation of ante mortem data.
4	Corresponding Point of Post Mortem Data	List the specific points of collection and correlation of post mortem data.
5	Signature of DMORT Leader	Show the name of the DMORT Leader. Include date signed (mm/dd/yy) and 24-hour time.
6	Print Name	Print the name of the DMORT Leader signing in number 5 above.
7	Signature of the atte nding Medical Examiner/Coroner	List the name of the attending Medical Examiner/Coroner. Include date signed (mm/dd/yy) and 24-hour time.
8	Print Name	Print the name of the attending Medical Examiner/Coroner signing in number 7 above.

HHS - 634

Declaration of Positive Identification of Disaster Victim

(1) This will certify that Disaster Victim (1) MRN- _____ has been positively identified as:

(2) Name of Victim: _____ Sex: _____Race:_____

The identification was made through collection and correlation of ante mortem and post mortem data. Significant matching points of Identification are list below.

(3) **Point** **Ante Mortem Data**

1._____

2._____

3._____

4._____

(4) **Corresponding Point** **Post Mortem Data**

1._____

2._____

3._____

4._____

To the best of my knowledge, and after careful review of all evidence presented, I believe enough ante mortem and post mortem evidence match to support my conclusion of positive identification of the above disaster victim.

(5) Signed: _____ Date: _____ Time: _____
DMORT Leader

(6) Print Name: _____

(7) Signed: _____ Date: _____ Time: _____
Medical Examiner/Coroner

(8) Print Name: _____

File Name: POS ID Form doc

VI. DMORT FORMS

TELEPHONE DOCUMENTATION OF NOTIFICATION OF NEXT OF KIN REGARDING POSITIVE ID, HHS - 635

Purpose

This form provides a guide for DMORT members when making telephone notification.

Preparation

The DMORT staff complete the information required on the form.

Distribution

The form is maintained in incident files and is tied with the MRN number for specific victims.

VI. DMORT FORMS

TELEPHONE DOCUMENTATION OF NOTIFICATION OF NEXT OF KIN REGARDING POSITIVE ID, HHS - 635

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	MRN	List the assigned Morgue Reference Number.
2	Name of Victim	Last name, first name, middle initial.
3	Notification Team	List specific DMORT including date and time of call.
4	Name of Person talked to	Name of person talked to and relationship as next of kin.
5	Confirmed Address	Address of person talked to and relationship as next of kin.
6	Notes	Specific notes taken during discussion with the next of kin.
7	Name of Person or Agency for Release Authorization	Name of person or agency to fax Release Authorization.
8	Address	Address of person or agency to fax Release Authorization.
9	Contact Person or Agency	Contact person of agency making the notification.
10	Talked to Agency, Date, Time	Talked to agency including date and time.
11	Action taken by Notification Team	Action taken by notification team including document number and team member notification.

HHS - 635

Telephone Documentation of Notification of Next of Kin Regarding Positive ID

(1) **MRN-**_____

(2) Name of Victim: _____

(3) Notification Team: _____ _____
(Print Name) (Print Name)

Date of Call: _____ Time:_____

(4) Name of Person talked to:
_____Relationship_____
(Please Print)

(5) Confirmed Address:
_____

(6) Notes:
_____

_____

_____

_____
(List additional notes on reverse of this page)
(7) Name of person or agency to Fax Release Authorization to:

_____

(8) Address:_____

Phone: _____Fax: _____

(9) Contact Person of Agency:
_____

(10) Talked to Agency: Date: _____ Time: _____

(11) Action taken by Notification Team

Document # _____ Faxed: Date: _____ Time: _____

Signed: _____ Signed: _____
(Notification Team member) (Notification Team member)

VI. DMORT FORMS

RELEASE OF PERSONAL EFFECTS, HHS - 636

Purpose

This form provides documentation for the custody and release of victim's personal effects.

Preparation

Preparation is the responsibility of the individual DMORT member gathering personal effects.

Distribution

The form is completed and maintained with victim identification information as part of the victim incident file.

VI. DMORT FORMS

RELEASE OF PERSONAL EFFECTS, HHS - 636

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	MRN	List the assigned Morgue Reference Number.
2	Name of Deceased	List the name of the deceased, last name, first name, and middle initial.
3	Item Description	List a specific item description(s) of the personal effects catalogued.
4	Signed	Signed by the identified next of kin include relationship, date and time.
5	Witness	Signature of the witness to the transfer, including date and time.

HHS - 636

Release of Personal Effects

(1) **MRN-**_____

(2) Name of Deceased: _____

(3) Item Description:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Additional items should be listed on another DMORT Form 350. Items such as Credit cards, store charge cards, drivers license, identification cards, checks, lottery tickets, or important documents should be photocopied on the back of this form or a photocopy attached to this form.

I/We certify that I/We represent all of the next of kin of the above, and do hereby accept custody of the Personal Items listed above.

(4) Signed:_____ Relationship: _____ Date: ____ Time: _____

_____
(Print Name)

Signed: _____ Relationship: _____ Date: ____ Time: ___

_____
(Print Name)

(5) Witness:_____ Released by: _____

_____ _____
(Print Name) (Print Name)

VI. DMORT FORMS

WINID2 MASTER LEGEND, HHS - 637

Purpose

The Master Legend provides DMORT personnel with added documentation sources on body identification. The form will be used in conjunction with sever traumatic accidents.

Preparation

The form is completed by the attending physician and accompanies the body through the examination process.

Distribution

Once the process of identification has been completed the paper work is filed for reference in the next of kin notification process.

VI. DMORT FORMS

WINID2 MASTER LEGEND, HHS - 637

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	Incident Name	List the name of the incident
2	Operational Period	Show operational period where form is completed. Include mm/dd/yy, and 24-hour clock time.
3	Tooth	Circle the appropriate primary and secondary code that describes the teeth recovered and any work done.
4	Body parts not recovered	Circle parts of the body that are missing and have not been recovered.
5	Ante Mortem Condition	Circle the appropriate condition of the body at the time of the examination.
6	Disposition	Circle the disposition that most closely matches the actual condition.
7	Type	Circle the appropriate type of accident and victim.
8	Sex	Circle the appropriate sex of the victim.
9	Hair Color	Circle the correct hair color of the victim.
10	Race	Circle the appropriate ethnic race of the victim.
11	Blood Type	Circle the appropriate blood type of the victim.
12	Virgin-No Restorations	Circle and list any difference noted.
13	Signature	Show legible signature of responsible examining official.
14	Date	Show the date of the examination mm/dd/yy.

WINID2 MASTER LEGEND

(1) INCIDENT NAME	(2) OPERATIONAL PERIOD

(3)**TOOTH**

Primary Codes – Required

M=Mesial	D=Distal
F=Facial	I=Incisal
C=Crown	X=Missing
U=Unerupted	J=Missing PM
O=Occlusal	V=Virgin
L=Lingual	/=No Info

TOOTH

Secondary Codes

A=Anomlay	R=Root Canal
T=Denture	H=Porcelain
Q=3/4 Crown	G=Gold
E=Resin	Z=Temp/Caries
B=Deciduas	S=Silver Amal
P=Pontic	N=Non-precious

(4)**BODY PARTS NOT RECOVERED**

CR-Cranium	MD-Mandible	TS-Torso
RA-Right Upper Arm	RF-Right Forearm	RH-Right Hand
LA-Left Upper Arm	LF-Left Forearm	LH-Left Hand
RL-Right Upper Leg	RC-Right Lower Leg	RT-Right Foot
LL-Left Upper Leg	LC-Left Lower Leg	LT-Left Foot

(5)**ANTE MORTEM CONDITION**

Good Preservation Decomposition-Early/Moderate/Advanced
Skeletonized Mummified Adipocere
Fire Burning Drowning Not Known

(6)**DISPOSITION**

Active Identified Cleared Unknown

(7)**TYPE**

Juvenile Endangered Disabled Accident Involuntary Disaster Misc

(8)**SEX:** Male Female Unknown

(9)**HAIR COLOR** Bald Black Blond Brown Gray Red White

(10)**RACE** African American Asian Hispanic Native American Other White A B

(11)**BLOOD TYPE** A+ A- B+ B- 0+ 0- AB+ AB-

(12)**VIRGIN-NO RESTORATIONS, list fractures, rotations, or other info in comments**

/=No Info (Tooth not present when examination done)
J=Missing PM (Tooth missing from accident)
Ante Mortem entered in comp have DISP=Active
Post Mortem entered in comp have DISP=Unknown
/ code on any tooth always returns / on best match or query
Primary teeth using secondary codes =B for comp, Ex=MEI 221 Ak 232
Matches and queries only on PRIMARY codes, just like CAPMI

(13) Signature	(14) Date

VI. DMORT FORMS

ANTE MORTEM DENTAL RECORD, HHS - 638

Purpose

The Ante Mortem Dental Record provides the basis for identification of a victim using dental records. The form will be used in conjunction with severe traumatic accidents.

Preparation

The form is completed by the attending dentist and accompanies the body through the examination process.

Distribution

Once the process of identification has been completed the form is filed for reference in the next of kin notification process.

VI. DMORT FORMS

ANTE MORTEM DENTAL RECORD, HHS – 638

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	Team Leader	List the DMORT Leader name and assisting dental personnel doing the examination. Include the DDS license number.
2	Name	List the victim's name - last name, first, middle initial.
3	Identification number	List the victim identification number and show the name of the medical examiner attending.
4	Originating Agency	Show the agency name originating the examination.
5	Originating Agency #	Show the agency number originating the examination.
6	Medical Examiner/Coroner	Show the medical examiner/corners name.
7	Medical Examiner/Coroner Number	Show the medical examiner/corners license number.
8	Date Of Birth	List the date of birth of the victim.
9	Date Of Last Contact	List the date that anyone made contact with the victim for the last time.
10	Body Part Not Recovered	Circle the appropriate body parts not recovered.
11	Post Mortem Condition	Circle the appropriate post mortem condition of the victim.
12	Disposition	Circle the appropriate disposition of the case.
13	Type	Circle the appropriate type of accident.
14	Sex	Circle the appropriate sex of the victim.
15	Race	Circle the appropriate race of the victim.
16	Height	List the height or range of height for the victim.
17	Weight	List the weight or range of weight for the victim.

VI. DMORT FORMS

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
18	Hair	Circle the appropriate victim hair color.
19	Eye Color	Circle the appropriate victim eye color.
20	Blood Type	Circle the appropriate blood type if the victim.
21	Comments	List any specific, pertinent comments.
22	Linked Graphic	Show the location and type of any graphic that is tied to the victim.
23	Comments	List any specific, pertinent comments.
24	Virgin-No Restorations	Circle and list any difference noted. These should be the same as listed on the HHS-636

ANTE MORTEM DENTAL RECORD

HHS-638

(1)Team Leader_____ 2nd DDS_____ 3rd DDS_____
Typist_____

(2)NAME (LAST, FIRST)_____

CIRCLE ANSWERS (WHERE APPLICABLE)

(3)ID#_____ ME_____ AK_____
NCIC# _____
(4)ORIGINATING AGENCY _____
(5)ORIGINATING AGENCY # _____
(6)MEDEX/COR _____
(7)MEDEX/COR # _____
(8)DATE OF BIRTH _____
(9)DATE OF LAST CONTACT _____TO_____
(10)BPNR-BODY PART NOT RECOVERED) _____
(11)PM COND- GOOD PRES
DECOMP: EARLY MOD ADV
SKELETINIZED MUMMIFIED

ADI PODICERE FIRE BURNING
DROWNING UNKNOWN

(12)DISP-ACTIVE IDENTIFIED CLEARED UNKNOWN
(13)TYPE-JUV ENDAN DSBLD ACCID INVOL DISAS MISC
(14)SEX- MALE FEMALE UNKNOWN
(15)RACE-AF AMER ASIAN HISP NAT AMER OTHER WHT
(16)HEIGHT (IN INCHES) _____ TO_____
(17)WEIGHT (IN POUNDS) _____TO_____
(18)HAIR COLOR-BALD BLK BLND BRWN GRAY RED WHT
(19)EYE COLOR-BLK BLUE BRWN GRN HAZ VIOLET WHT
(20)BLOOD TYPE- A+ A- B+ B- 0+ 0- AB+ AB-
(21)COMMENTS_____
_____
_____
_____

(22)LINKED GRAPHIC _____

	A	P	G
1			
2			
3			
4			
5			

(23)COM_____
_____
_____

FDI	1°	US	DESCRIPTION	WinID CODE
18		1		
17		2		
16		3		
15A		4		
14B		5		
13C		6		
12D		7		
11E		8		
21	F	9		
22	G	10		
23	H	11		
24	I	12		
25	J	13		
26		14		
27		15		
28		16		
38		17		
37		18		
36		19		
35	K	20		
34	L	21		
33	M	22		
32	N	23		
31	O	24		
41	P	25		
42	Q	26		
43	R	27		
44	S	28		
45	T	29		
46		30		
47		31		
48		32		

(24)VIRGIN=NO RESTORATIONS- LIST
_____
_____
_____

FRACTURES, ROTATIONS, ETC IN COMMENTS
/=No Info (Tooth not present when examination done)
J=Missing PM (Tooth missing from accident)

Primary Codes – Required

M=Mesial	D=Distal
F=Facial	I=Incisal
C=Crown	X=Missing
U=Unerupted	J=Missing PM
O=Occlusal	V=Virgin
L=Lingual	/=No Info

Secondary Codes

A=Anomlay	R=Root Canal
T=Denture	H=Porcelan
Q=3/4 Crown	G=Gold
E=Resin	Z=Temp/Caries
B=Decidous	S=Silver Amal
P=Pontic	N=Non-precious

FILE NAME=DENT-ANTE-HHS-636

VI. DMORT FORMS

POST MORTEM DENTAL RECORD, HHS - 639

Purpose

Provide a location for the recording of Post Mortem documentation for an accident of major multi-causality incident

Preparation

The form will be completed by the attending examiner and will accompany the body through the examination process.

Distribution

At the conclusion of the examination the form will be filed with the Document Unit at a permanent record of the victim identification.

VI. DMORT FORMS

POST MORTEM DENTAL RECORD, HHS – 639

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	Team Leader	List the name of the DMORT Leader and assisting dental personnel.
2	Post Mortem Examiners	List the post mortem staff involved with the examination.
3	Description	Show the appropriate WINID2 Codes listed on the HHS-637

HHS-639

POSTMORTEM DENTAL RECORD

(1)TEAM LEADER_____ 2nd DS_____ 3rd DDS_____ Typist_____

(2)PM1_____ PM2_____ PM3_____ PM4_____ PM5_____

CIRCLE ANSWERS (WHERE APPLICABLE)

(3)DESCRIPTION WinID CODE US 1° FDI ID#_____ ME_____ AK_____ NCIC#

_____ _____	1		18	ORIGINATING AGENCY _____
_____ _____	2		17	ORIGINATING AGENCY #
_____ _____	3		16	MEDEX/COR
_____ _____	4	A	15	MEDEX/COR #
_____ _____	5	B	14	DATE BODY FOUND
_____ _____	6	C	13	EST. AGE (IN YEARS)
_____TO_____				
_____ _____	7	D	12	BPNR (BODY PART NOR RECVERED) _____
_____ _____	8	E	11	PM COND- GOOD PRES DECOMP: EARLY MOD ADV SKELETINIZED MUMMIFIED ADI PODICERE FIRE BURNING DROWNING UNKNOWN
_____ _____	9	F	21	DISP- ACTIVE IDENTIFIED CLEARED UNKNOWN
_____ _____	10	G	22	TYPE-JUV ENDANG DSABLD ACCID INVOL DISASTER MISC
_____ _____	11	H	23	SEX- MALE FEMALE UNKNOWN
_____ _____	12	I	24	RACE- AF AMER ASIAN HISP NAT AMER OTHER WHITE
_____ _____	13	J	25	HEIGHT (IN INCHES)
_____TO_____				
_____ _____	14		26	WEIGHT (IN POUNDS)
_____TO_____				
_____ _____	15		27	HAIR COLOR- BALD BLK BLND BRWN GRAY RED WHT
_____ _____	16		28	EYE COLOR-BLK BLUE BRWN GRN HAZ VIOLET WHITE
				BLOOD TYPE- A+ A- B+ B- 0+ 0- AB+ AB-
_____ _____	17		38	COMMENTS_____
_____ _____	18		37	_____
_____ _____	19		36	_____
_____ _____	20	K	35	_____
_____ _____	21	L	34	LINKED GRAPHIC _____
_____ _____	22	M	33	A P G
_____ _____	23	N	32	1 _____ _____ _____
_____ _____	24	O	31	
				2 _____ _____ _____
_____ _____	25	P	41	
_____ _____	26	Q	42	3 _____ _____ _____
_____ _____	27	R	43	
_____ _____	28	S	44	4 _____ _____ _____

_____	_____	29	T	45				
_____	_____	30		46	5	_____	_____	_____
_____	_____	31		47				
_____	_____	32		48	COM	_____	_____	_____
						_____	_____	_____
						_____	_____	_____
						_____	_____	_____
						_____	_____	_____
						_____	_____	_____
						_____	_____	_____

VIRGIN=NO RESTORATIONS, LIST FRACTURES, ROTATIONS ETC IN COMMENTS
/=No Info (Tooth not present when examination done)
J=Missing PM (Tooth missing from accident)

Primary Codes – Required

M=Mesial	**D=Distal**
F=Facial	**I=Incisal**
C=Crown	**X=Missing**
U=Unerupted	**J=Missing PM**
O=Occlusal	**V=Virgin**
L=Lingual	**/=No Info**

Secondary Codes

A=Anomlay	**R=Root Canal**
T=Denture	**H=Porcelan**
Q=3/4 Crown	**G=Gold**
E=Resin	**Z=Temp/Caries**
B=Decidous	**S=Silver Amal**
P=Pontic	**N=Non-precious**

FILE NAME=DENT-POST-WinID.doc

VI. DMORT FORMS

POSITIVE DENTAL ID SUMMARY FORM, HHS-640

Purpose

This form allows DMORT examiners to make a positive identification of victims through the use of dental documentation

Preparation

The form is completed primarily by the assigned Anthropologist and Pathologist.

Distribution

The form becomes a portion of the total and final record for victims of accidents of multi-causality incidents. The Document Unit will maintain a record of all forms on the incident.

VI. DMORT FORMS

POSTIVE DENTAL ID SUMMARY FORM, HHS-640

ITEM NUMBER	ITEM TITLE	INSTRUCTIONS
1	Name	List the victim's name, last name, first name, and middle initial.
2	ME#	Show the license number of the assigned Medical Examiner/Coroner.
3	AK#	Show the license number of the assigned AK.
4	Dental Records	Show information on a tooth by tooth examination of the victim.
5	Dental Examiner	The form will be signed and dated by three assigned dental examiners.
6	Dental Leader	The dental team leader signs as verification of the examination completed.
7	Anthropology	Print the name of the assigned, in-charge anthropologist, sign and date.
8	Pathology	Print the name of the assigned, in-charge pathologist, sign and date.
9	DMORT Leader	Print the name of the assigned, in-charge DMORT Leader, sign and date.
10	USPHS	Print the name of the assigned, in-charge PHS representative (MST Leader), sign and date.

POSITIVE DENTAL ID
SUMMARY FORM HHS-640

NAME (last, first) _____ ME # _____ AK#

D.O.B. _____ SSN# _____ Date of ID: _____

US		US	1	FDI
1		1		18
2		2		17
3		3		16
4		4	A	15
5		5	B	14
6		6	C	13
7		7	D	12
8		8	E	11
9		9	F	21
10		10	G	22
11		11	H	23
12		12	I	24
13		13	J	25
14		14		26
15		15		27
16		16		28
17		17		38
18		18		37
19		19		36
20		20	K	35
21		21	L	34
22		22	M	33
23		23	N	32
24		24	O	32
25		25	P	41
26		26	Q	42
27		27	R	43
28		28	S	44
29		29	T	45
30		30		46

APPROVED

DENTAL EXAMINER 1

Print Name

Signature

DENTAL EXAMINER 2

Print Name

Signature

DENTAL EXAMINER 3

Print Name

Signature

DENTAL TEAM LEADER

Print Name

31		31	47	
32		32	48	Signature

Anthropology (print)	Signature/date
Pathology (print)	Signature/date
DMORT Leader (print)	Signature/date
USPHS (print)	Signature/date

VIP FORMS

VIP Personal Information

Incident

Incident Date

RM #

Last / Suffix / First / Middle | Sex | If Female/Maiden Name | Age

DOB MM/DD/YYYY | Race | Ethnic Origin | Ethnic Origin Other | SSN # / ID #

Address | Apt # | City | State | Zip | County | Country

Birth City | State or Country | Birth Hospital | Inside City Limits | Religious Preference

Education: level completed: | Elem/Second (0-12): | College | Degree Earned:

Alias 1 Last First Middle | Alias 2 Last First Middle

Phone (H) (W) (Cell) | Cell Type: _____ | Carrier: _____

Status ○ Is Married ○ Never Married ○ Widowed ○ Divorced ○ Separated ○ Civil Union ○ Unk | Wedding Date

Spouse Last Suffix Maiden/birth Name First Middle ○ Living ○ Deceased ○ Unknown

Father Last Suffix First Middle ○ Living ○ Deceased ○ Unknown

Mother Last Maiden/Birth Name First Middle ○ Living ○ Deceased ○ Unknown

Informant

Last Suffix First Middle

Address City State Zip

Home Phone Work Phone Cell Phone Country

E-mail

Type of Initial Contact Initial Contact Date

Relationship: ○ Spouse ○ Daughter ○ Life Partner ○ Father ○ Uncle ○ Other ○ Mother ○ Aunt ○ Brother ○ Cousin ○ Sister ○ Employer ○ Son ○ Friend

Other:

Legal Next of Kin

OK to Contact Legal Next of Kin? ○ Yes ○ No | Make A Case Note To Explain

Last Suffix First Middle

Address City State Zip

Home Work Cell Phone Country

E-mail

Relationship: ○ Spouse ○ Daughter ○ Life Partner ○ Father ○ Uncle ○ Other ○ Mother ○ Aunt ○ Brother ○ Cousin ○ Sister ○ Employer ○ Son ○ Friend

Other:

Contacts

1 Permanent Contact: ☐ YES / Additional Contact? ☐ YES

Last / Suffix / First / Middle

Address City State Zip

Home Phone Work Phone Cell Phone

E-mail | Type of Initial Contact | Initial Contact Date

Relationship: ○ Spouse ○ Daughter ○ Life Partner ○ Father ○ Uncle ○ Other ○ Mother ○ Aunt ○ Brother ○ Cousin ○ Sister ○ Employer ○ Son ○ Friend

Other:

VIP Physical Description

Incident

Incident Date

RM #

Last	Suffix	First	Middle	Age	DOB	Sex	Race
	/	/	/				

Complexion: General Build:

Height Inches: / Height cm Approx. Weight (Pounds): / Weight Kilos

Hair Info

Hair Color: ☐ Auburn ☐ Blonde ☐ Gray ☐ Sald and Pepper ☐ Dyed ☐ Black ☐ Brown ☐ Red ☐ White ☐ Other — Describe Other:

Hair Length: ☐ Bald ☐ Short < 3" ☐ Male Pattern Baldness: ☐ Shaved ☐ Medium ☐ Long — Describe Male Pattern Baldness:

Hair Accessory: ☐ Extensions ☐ Hair Piece ☐ Hair Transplant ☐ Wig ☐ N/A

Hair Description: ☐ Curly ☐ Wavy ☐ Straight ☐ N/A ☐ Other:

Facial Hair Type: ☐ Clean Shaven ☐ Beard & Mustache ☐ Goatee ☐ Sideburns ☐ N/A ☐ Mustache ☐ Beard ☐ Stubble ☐ Lower Lip

Facial Hair Color: ☐ Auburn ☐ Blonde ☐ Gray ☐ Sald and Pepper ☐ Dyed ☐ Black ☐ Brown ☐ Red ☐ White ☐ Other — Facial Hair Notes:

Eyes

Eye Color: ☐ Blue ☐ Brown ☐ Green ☐ Hazel ☐ Gray ☐ Black ☐ Other:

Eye Status: ☐ Both Intact ☐ Missing R ☐ Missing L ☐ Glass R ☐ Glass L ☐ Cataract ☐

Optical Lens: ☐ Contacts ☐ Glasses ☐ Implants ☐ None Desc.

Optical Color/Description of Glasses / Contacts:

Nails

Fingernail Type: ○ Natural ○ Artificial ○ Unknown Length ○ Extremely Long ○ Long ○ Medium ○ Short

Fingernail Color Description

Toenail Type: ☐ Natural ☐ Artificial ☐ Unknown

Toenail Color Toenail description

Body Piercing(s)? Yes No Unk Photos? Yes No Unk Photo Location

#	Location	Side	Quantity	Description (include evidence of old piercings)	Photo
1					
2					
3					
4					
5					

Tattoo(s) ○ Yes ○ No ○ Unk Photos? ○ Yes ○ No ○ Unk Photo Location

#	Location	Side	Tattoo Description
1			
2			
3			
4			
5			

VIP Medical History

Incident
Incident Date

RM #

Last / Suffix / First / Middle | Age | DOB | Sex | Race

Dentist

Dentist First Last Sal — Name of Practice:
Address — City — State — Zip
E-mail Address: — Phone W — Alt: — Fax
2nd Dentist: — Dental Insurance Company:
☐ Braces ☐ Bridge ☐ Caps/Crowns ☐ Fillings ☐ Dentures ☐ Edentulous ☐ Tooth Jewelry ☐ Unknown

Doctor

Physician First Middle Last Sal — Practice Name
Address — Physician Type
City — State — Zip — Reason Seen:
Phone W — Phone H — Date Last Seen:
Phone C — Fax — Email

Doctor

Physician First Middle Last Sal — Practice Name
Address — Physician Type
City — State — Zip — Reason Seen:
Phone W — Phone H — Date Last Seen:
Phone C — Fax — Email

Medical Facility Visited / Type? — Medical Facility / Name
Medical History? ☐ Cancer ☐ High Blood Pressure ☐ Lung Disease ☐ Pregnancy ☐ Stroke ☐ Other
Medical History Notes / Other?
Medical Radiographs? — Medical Radiographs Location:
○ Yes ○ No ○ Unk
Potential Type of Radiographs - and dates taken if known:

Old Fractures: ○ Yes ○ No ○ Unk — Description:
Foreign Objects : ○ Yes ○ No ○ Unk ☐ Pacemaker ☐ Bullets ☐ Implants ☐ Needles ☐ Shrapnel ☐ Other
Describe Other:
Surgery: ○ Yes ○ No ○ Unk
☐ Gall Bladder ☐ Laparotomy ☐ Reconstructive
☐ Appendectomy ☐ Caesarean ☐ Open heart
☐ Tracheotomy ☐ Mastectomy ☐ Other

Unique Characteristics ○ Yes ○ No ○ Unk — Description of: Scars or unusual body features:

Prosthetic(s) ○ Yes ○ No ○ Unk — Prosthetic Location/Description

Circumcised ? ○ Yes ○ No ○ Unk — Tobacco User ? ○ Yes ○ No ○ Unk — Tobacco Type ?
Diabetic? ○ Yes ○ No ○ Unk — If Female, was she currently pregnant? ○ Yes ○ No ○ Unk
If Female, was she pregnant during the last 12 months? ○ Yes ○ No ○ Unk

VIP Personal Information

Incident

Incident Date

RM #

Last	Suffix	First	Middle	Age	DOB	Sex	Race
/	/	/					

GROUP TRAVEL INFORMATION

Traveling with: ○ Alone ○ Individual ○ Group

Group Type: Family, Sports, Church, Military, etc

Family or Group Name:

Date last seen? **Last seen by?**

Last seen with:

Last location Victim was seen:

MILITARY INFORMATION

Military Service ○ Yes ○ No ○ Unk

Nation Served | **Branch** | **Service Number** | **Approximate Service Date**

DNA Taken: ○ Yes ○ No ○ Unk

Comments regarding Military History:

CRIMINAL HISTORY OR FINGER PRINT INFORMATION

Criminal History: ○ Yes ○ No ○ Unk

Date of Last Arrest: **Date Released:** **Arrested By:** **Prison or Jail Location:**

Ever Printed: ○ Yes ○ No ○ Unk

Print Types: **Location of Prints:**

EMPLOYMENT HISTORY

Work Status: **Usual Occupation/Title:**

Type of Business / Industry: **Employer:** **Employer Phone:**

Employer Address:

ADDITIONAL PERSONAL DATA

List memberships: Clubs, Fraternities, etc.

List Social Media used and user names: (Facebook, Twitter etc.)

Additional Data:

Incident
Incident Date

RM #

Last	Suffix	First	Middle	Age	DOB	Sex	Race
/	/	/					

WATCH:

Normally wears a Watch:	Type	Make	Band Material	Band Color	Face Color	Where Worn ?
○ Yes ○ No ○ Unk						

Description

Inscription ○ Yes ○ No ○ Unk

Photo Available
○ Yes
○ No
○ Unk

JEWELRY:

	Jewelry/Type / Style	Material Color/ Stone Color?	Size / Where Worn/ Frequently Worn?	Description	Photo Available / Inscription
1			○ Yes ○ No		○ Yes ○ No ○ Unk
2			○ Yes ○ No		○ Yes ○ No ○ Unk
3			○ Yes ○ No		○ Yes ○ No ○ Unk
4			○ Yes ○ No		○ Yes ○ No ○ Unk
5			○ Yes ○ No		○ Yes ○ No ○ Unk
6			○ Yes ○ No		○ Yes ○ No ○ Unk
7			○ Yes ○ No		○ Yes ○ No ○ Unk

VIP Clothing and Personal Effects

Incident _____

Incident Date _____

RM # _____

Last	Suffix	First	Middle	Age	DOB	Sex	Race
	/ /						

CLOTHING:

Clothing Items	Color	Description	Size

Wallet: Description _____

Contents _____

Purse: Description _____

Contents _____

Contents Left _____

Contents Right _____

VIP Family

Incident
Incident Date

RM #

Last	Suffix	First	Middle	Age	DOB	Sex	Race
/	/	/					

Potential Living Biological Donors

All BIOLOGICAL Relatives of Missing Individual
Such as: Mother/Father/Spouse/Sister/Brother/Children/Uncle/Aunt/Cousin

Are we Collecting Family Reference DNA ○ Yes ○ No

Last Name	First Name	Middle Name	Suffix	SS# Last 4	DOB	Sex	Relationship
Address	City	State Zip	Phone 1	E-Mail			

Last Name	First Name	Middle Name	Suffix	SS# Last 4	DOB	Sex	Relationship
Address	City	State Zip	Phone 1	E-Mail			

Last Name	First Name	Middle Name	Suffix	SS# Last 4	DOB	Sex	Relationship
Address	City	State Zip	Phone 1	E-Mail			

Last Name	First Name	Middle Name	Suffix	SS# Last 4	DOB	Sex	Relationship
Address	City	State Zip	Phone 1	E-Mail			

Last Name	First Name	Middle Name	Suffix	SS# Last 4	DOB	Sex	Relationship
Address	City	State Zip	Phone 1	E-Mail			

Last Name	First Name	Middle Name	Suffix	SS# Last 4	DOB	Sex	Relationship
Address	City	State Zip	Phone 1	E-Mail			

Last Name	First Name	Middle Name	Suffix	SS# Last 4	DOB	Sex	Relationship
Address	City	State Zip	Phone 1	E-Mail			

Last Name	First Name	Middle Name	Suffix	SS# Last 4	DOB	Sex	Relationship
Address	City	State Zip	Phone 1	E-Mail			

Primary donor for Nuclear DNA Analysis

An "appropriate family member" for **nuclear DNA Analysis** is someone who is biologically related to and only one generation removed from the deceased. The following are the family members who are appropriate donors to provide reference specimens, and in the order of preference (family members highlighted in bold print are the most desirable):

1. Natural (Biological) **Mother and Father**, AND
2. **Spouse** and Natural (Biological) **Children**, AND
3. A Natural (Biological) Mother or Father and victim's biological children, OR
4. Multiple Full Siblings of the Victim (i.e., children from the same Mother and Father).

VIP Interviewer Information

RM #

Name _____ / _____ / _____
Last First Middle

Interview Location _____

Date _____ **Time** _____
(MM/DD/YYYY)

Interviewer Name _____
Full Name

Interviewing Agency _____

Interviewer Home Information

City: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Interviewer Onsite Information

Interviewer Onsite address: _____
Location Name and Street,City. State and Room #

Interviewer Onsite phone: _____

Interviewer Onsite cell: _____

Reviewer Info

Reviewer Name: _____

Reviewing Agency: _____

Reviewer's Signiture: _____

Site Recovery #

Put N/A in all unused fields.

Victim Site Recovery Form

Incident

Incident Date

Morgue Reference No.

Recovery Date MM/DD/YYYY

Time: 24 hour (00:00)

Classification of Remains:

Choices: Complete HR (C/HR), Fragmented HR (F/HR) or Common Tissue (CT/HR)

Recovery Grid #:

GPS of Recovery:

Place / Address of Recovery:

Condition: select all that apply

- ☐ Autopsied Previously
- ☐ Burned-Partial Thickness
- ☐ Burned-Full Thickness
- ☐ Cremains
- ☐ Decomposed
- ☐ Embalmed
- ☐ Fragmented
- ☐ Fresh
- ☐ Mummified
- ☐ Saponified
- ☐ Scavenged
- ☐ Skin Slippage
- ☐ Skeletonized-Partial
- ☐ Skeletonized-Full
- ☐ Wet-Environmental

Description of Remains:

Position Remains Found in:

Estimated Age: ○ Baby/Child ○ Adolescent ○ Young Adult ○ Middle Aged ○ Elderly ○ No Estimate

Estimated Sex: ○ Male ○ Female ○ Not Assessed **Estimated Race:**

Clothing on Remains: (brief description) ○ Yes ○ No

Personal Effects on Remains: (brief description) ○ Yes ○ No

Recovery Comments:

Presumptive FIELD ID: Last First Middle

ID Based On: DOB (MM/DD/YYYY) SSN ID# / Drivers license # / State

No. of Photo's Taken: **Camera assigned Start-End Image No's**

Recovered By: Name and Agency (if applies) Phone # Date Recovered Time Recovered

Delivered to Transport Staging: Name and Agency (if applies) Phone # Date Delivered Time Delivered

Site Recovery Report Completed by: Name and Agency (if applies) Phone #

Delivered to Morgue by: Agency Phone #

Team Leader: Date Delivered Time Delivered

Barcode #

Place Barcode Sticker Here

Tracking Form

Incident

To be attached to the front of each Disaster Victim Packet (DVP). Incident Date

Morgue Reference No.

Site Recovery #

Morge Reference #

ME/C #

Date Received by Admitting:

Date Processed In Morgue:

Tracker:

Name

Presumptive ID: _____, _____ _____, _____

Last Name First Middle Suffix

DOB Gender SSN

Section Leader MUST print and sign their name below when processing completed. "No" = nothing was performed at station.

Morgue Station:		Station Completed:		Print Station Leader's Name	Station Tracking
Admitting	Triage	Yes	No		
Radiology		Yes	No		
Pathology		Yes	No		
Photography		Yes	No		
Personal Effects		Yes	No		
Fingerprints		Yes	No		
Odontology		Yes	No		
Anthropology		Yes	No		
DNA		Yes	No		
Embalming		Yes	No		
Admitting/Exit		Yes	No		

From Site Recovery Description of Remains:

Tracking Form Comments

To be completed by Tracker at end of Processing.

Barcode Number:

This Bag Also Produced Morgue Reference No's:

Image Inventory:

 # Radiographs:

 # Pathology Photos:

 # Personal Effects Photos:

 # Fingerprint Photos:

 # Dental Photos:

 # Anthropology Photos:

Place Barcode Sticker Here.

Examiners

Fingerprinting

Incident

Incident Date

Date of Exam:

Morgue Reference No.

Classification of Remains:

Condition of Hands: (burned, decomposed, skeletonized, scavenged, etc.)

Condition of Right Hand:

Condition of Left Hand:

Fingers Printed ○ Yes ○ No **If not printed why?**

(Check all fingers printed below)

Right Hand Describe Condition if Needed:

- ☐ Thumb 1
- ☐ Index 2
- ☐ Middle 3
- ☐ Fourth 4
- ☐ Little 5

Left Hand Describe Condition if Needed:

- ☐ Thumb 6
- ☐ Index 7
- ☐ Middle 8
- ☐ Fourth 9
- ☐ Little 10

Right Palm Printed: ○ Yes ○ No **Left Palm Printed:** ○ Yes ○ No

Footprints Taken: Right Foot ○ Yes ○ No **Left Foot** ○ Yes ○ No

Condition of Feet:

Fingerprint Exam Notes:

Fingerprint Photos Taken:

Examining Anthropologist

Scribe

Exam Date:

Anthropology 1.
Page 1 of 2

Incident

Incident Date

Morgue Reference No.

Estimated Age

Lower Age Range Upper Age Range

Estimated Sex

☐ Male ☐ Male possible ☐ Unknown
☐ Female ☐ Female possible

Classification of Remains:

Condition of Remains:

☐ Autopsied Previously	☐ Cremains	☐ Fragmented	☐ Saponified	☐ Skeletonized-Partial
☐ Burned-Partial Thickness	☐ Decomposed	☐ Fresh	☐ Scavenged	☐ Skeletonized-Full
☐ Burned-Full Thickness	☐ Embalmed	☐ Mummified	☐ Skin Slippage	☐ Wet-Environmental

Skeletal Race:

○ Caucasian ○ American Indian ○ Other - Specify
○ Black ○ Hispanic
○ Asian ○ Undetermined

Skeletal Build:

○ Small/Gracile ○ Undetermined
○ Medium/Intermediate
○ Large/Robust

Estimated Stature

(cm)

(in)

Missing Parts

☐ None - Intact Body	☐ R Upper Arm	☐ Partial L Upper Arm	☐ R Lower Leg	☐ Partial L Lower Leg
☐ Cranium	☐ Partial R Upper Arm	☐ L Forearm	☐ Partial R Lower Leg	☐ L Foot
☐ Partial Cranium	☐ R Forearm	☐ Partial L Forearm	☐ R Foot	☐ Partial L Foot
☐ Mandible	☐ Partial R Forearm	☐ L Hand	☐ Partial R Foot	
☐ Partial Mandible	☐ R Hand	☐ Partial L Hand	☐ L Upper Leg	
☐ Torso	☐ Partial R Hand	☐ R Upper Leg	☐ Partial L Upper Leg	
☐ Partial Torso	☐ L Upper Arm	☐ Partial R Upper Leg	☐ L Lower Leg	

Unique Skeletal Features (Pathology, Healed Trauma, Unique Identifiers, Etc.)

☐ Cranium	☐ Partial R Upper Arm	☐ L Forearm	☐ Partial R Lower Leg	☐ L Foot
☐ Partial Cranium	☐ R Forearm	☐ Partial L Forearm	☐ R Foot	☐ Partial L Foot
☐ Mandible	☐ Partial R Forearm	☐ L Hand	☐ Partial R Foot	
☐ Partial Mandible	☐ R Hand	☐ Partial L Hand	☐ L Upper Leg	
☐ Torso	☐ Partial R Hand	☐ R Upper Leg	☐ Partial L Upper Leg	
☐ Partial Torso	☐ L Upper Arm	☐ Partial R Upper Leg	☐ L Lower Leg	
☐ R Upper Arm	☐ Partial L Upper Arm	☐ R Lower Leg	☐ Partial L Lower Leg	

Specify and Describe Below

Skeletal Diagram Used: ○ Yes ○ No

Unique Skeletal Features: (Include location, type and description)

- OVER -

Examining Anthropologist

Scribe

Exam Date:

Anthropology 2.
Page 2 of 2

Incident

Incident Date

Morgue Reference No.

Evidence of Ante Mortem Fractures (Old Fractures) ○ Yes ○ No

Skeletal Trauma: (include location, type and description)

Race / Ancestry Based On:

Age Based On:

Stature Based On: (include measurements)

Anthropology Dental Comments:

Anthropology Miscellaneous Comments:

Examining Radiologist

Scribe

Exam Date:

Radiology 1

Incident

Incident Date

Morgue Reference No.

Classification of Remains:

This is Inital X-ray Exam: ◯ This includes a Secondary X-ray Exam: ◯

Number of Initial Radiographs: Number of Additional Radiographs:

Radiology Technologist(s): Name (list all who worked on THIS case):

Reason for Additional X-rays:

Pacemaker Present: ○ Yes ○ No Implants Present: ○ Yes ○ No

Notable Findings Per Technologist:

Technologist notified the following person of "notable findings":

Name of Specialist	Morgue Section	Date Notified

- OVER -

Examining Radiologist

Scribe

Exam Date:

Radiology 2

Incident

Incident Date

Morgue Reference No.

Assessment Done By: List Names

Type of Forensic Specialist: ☐ Radiologist ☐ Pathologist ☐ Anthropologist ☐ Dentist

Estimated Gender: ○ Male ○ Female ○ Not Assessed

Estimated Age: ○ 0-2 ○ 3-5 ○ 6-10 ○ 11-20 ○ 21-30 ○ 31-40 ○ 41-50 ○ 51-70 ○ 71+

Radiology Specific Findings:

1 **Location:** **Side:** **Type:**

Detailed Description:

2 **Location:** **Side:** **Type:**

Detailed Description:

3 **Location:** **Side:** **Type:**

Detailed Description:

4 **Location:** **Side:** **Type:**

Detailed Description:

5 **Location:** **Side:** **Type:**

Detailed Description:

Comments:

Scribe _____ Exam Date: _____

Pathology 1
Page 1 of 3

Incident _____
Incident Date _____
Morgue Reference No. _____

Gender: ○ Male ○ Female ○ Undetermined

Estimated Age: ○ 0-2 ○ 3-5 ○ 6-10 ○ 11-20 ○ 21-30 ○ 31-40 ○ 41-50 ○ 51-70 ○ 71+

Estimated Race: ○ Caucasian ○ Black ○ Asian ○ American Indian ○ Hispanic ○ Undetermined ○ Other - specify

Classification of Remains:

Build ○ Small/Gracile ○ Medium/Intermediate ○ Large/Robust ○ Undetermined

Lividity: ○ Fixed ○ Unfixed

Location of Lividity - required

Condition of Remains: check all that apply

- ☐ Autopsied Previously
- ☐ Burned-Partial Thickness
- ☐ Burned-Full Thickness
- ☐ Cremains
- ☐ Decomposed
- ☐ Embalmed
- ☐ Fragmented
- ☐ Fresh
- ☐ Mummified
- ☐ Saponified
- ☐ Scavenged
- ☐ Skin Slippage
- ☐ Skeletonized-Partial
- ☐ Skeletonized-Full
- ☐ Wet-Environmental

Rigor - check all that apply

- ☐ Absent
- ☐ Complete, all muscles
- ☐ Hands, Feet
- ☐ Fingers, Toes
- ☐ Jaw/Face Only
- ☐ Large Extremities
- ☐ Resolving

Height inches: _____ **cm:** _____ **Estimated Weight lbs:** _____ **kg:** _____

Hair

Color: ○ Auburn ○ Black ○ Blonde ○ Brown ○ Gray ○ Red ○ Salt & Pepper ○ White ○ Other - specify

Length: ○ Short ○ Medium ○ Long **If measured: cm** _____ **Inches** _____ ○ Shaved ○ Bald ○ Male Pattern Baldness ○ Undetermined

Description: ○ Curly ○ Wavy ○ Straight ○ N/A ○ Other - specify

Accessory: ○ Extension ○ Hair Piece ○ Hair Transplant ○ Wig ○ Other - Specify

Facial Hair: ○ Yes ○ No

Facial Hair Color: ○ Auburn ○ Black ○ Blond ○ Brown ○ Gray ○ Red ○ Salt & Pepper ○ White ○ NA ○ Other - Specify

Facial Hair Type: ☐ Clean Shaven ☐ Moustache ☐ Beard & Moustache ☐ Beard ☐ Goatee ☐ Stubble ☐ Sideburns ☐ Lower Lip ☐ Other - specify

Eyes

Color: ☐ Blue ☐ Brown ☐ Green ☐ Grey ☐ Hazel ☐ Undetermined ☐ Other - specify

Condition: ☐ Both Intact ☐ Missing-Right ☐ Glass-Right ☐ Cataract-Right ☐ Missing-Left ☐ Glass-Left ☐ Cataract-Left ☐ Other - specify

Aids: ☐ None ☐ Contacts ☐ Glasses ☐ Corneal Implant-Left ☐ Corneal Implant-Right ☐ Other - specify

Teeth

Present: ○ Yes ○ No

Dentures: ○ Yes ○ No ☐ Upper Engraved/Labeled ☐ Lower Engraved/Labeled

Appliance: ○ Yes ○ No **Type and location:** _____

Type and location: _____

Scribe

Exam Date:

Pathology 2 for DVP

Incident

Incident Date

Morgue Reference No.

Nails

Fingernails **Type** ◯ Natural ◯ Artificial ◯ Not known **Color**

Length ◯ Extra Long ◯ Long ◯ Medium ◯ Short **Description**

Toenails **Color** **Description**

External Genitalia
(check all that apply)

☐ Female ☐ Circumcised ☐ Circumcision Undetermined
☐ Male ☐ Uncircumcised ☐ No Identifiable External Genitalia

Evidence of Possible Surgery: As Indicated By Scars, Sutures, etc. ◯ Yes ◯ No

(check all that apply)

☐ Amputation
☐ Appendectomy
☐ Brain
☐ Caesarean
☐ Cardiac
☐ Gall Bladder
☐ Laparotomy
☐ Mastectomy
☐ Reconstructive
☐ Tracheotomy
☐ Other - Specify

Specify Other Surgeries here:

Scars, Amputation, Birth Marks, Deformities:

Category	Location	Side	Description
Scars:			
Amputation:			
Birth Mark:			
Deformity:			

Category	Location	Side	Description
Scars:			
Amputation:			
Birth Mark:			
Deformity:			

Category	Location	Side	Description
Scars:			
Amputation:			
Birth Mark:			
Deformity:			

Category	Location	Side	Description
Scars:			
Amputation:			
Birth Mark:			
Deformity:			

Category	Location	Side	Description
Scars:			
Amputation:			
Birth Mark:			
Deformity:			

Examining Pathologist

Scribe _____

Exam Date:

Pathology 3 for DVP

Incident

Incident Date

Morgue Reference No.

Body Piercing and Tattoos **Body Piercing(s)** ○ Yes ○ No **Tattoo(s)** ○ Yes ○ No

Total # Path Photos Taken **Image #'s:**

Pathology Narrative:

Body Diagram Used ○ Yes ○ No **Referred for Autopsy** ○ Yes ○ No **Tox Collected** ○ Yes ○ No

	Category	Location	Position	Description
	Tattoo			
	Piercing			

	Category	Location	Position	Description
	Tattoo			
	Piercing			

	Category	Location	Position	Description
	Tattoo			
	Piercing			

	Category	Location	Position	Description
	Tattoo			
	Piercing			

	Category	Location	Position	Description
	Tattoo			
	Piercing			

Foreign Objects / Implants / Prosthetics / Orthopedics In Body **Foreign Object Present:** ○ Yes ○ No

Type: **Type Other:** **Position:** **Location:**

☐ Pacemaker ☐ Prosthetic ☐ Other - Specify

Description: **Removed from Body:** ○ Yes ○ No

Type: **Type Other:** **Position:** **Location:**

☐ Pacemaker ☐ Prosthetic ☐ Other - Specify

Description: **Removed from Body:** ○ Yes ○ No

Type: **Type Other:** **Position:** **Location:**

☐ Pacemaker ☐ Prosthetic ☐ Other - Specify

Description: **Removed from Body:** ○ Yes ○ No