P.O. Box 140647
Dallas, TX 75214-0647
www.lonestarautopsy.com

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QUESTIONNAIRE FORM

Name of deceased:____

Address of deceased:____Zip_____________________

Date of birth:_____________________________Age:__________Race:__________________________Sex:_______

Date of death:____________________________________Exact time of death:_________________________ a.m. p.m.

Place of death (include address):____

____

Name/Address/ phone number where report(s) should be sent:____

____Zip Code____________________

Phone #:____

Name of hospital/facility where deceased received treatment (if applicable):____________________________________

____

Why is an autopsy being requested? (Provide as much detail as necessary; you may use back of sheet):

Medical conditions which the deceased had (i.e. diabetes, high blood pressure, coronary artery disease, cancer including site of cancer if known):

List of Medications deceased was taking:

What funeral home is being used? (include contact person, address, phone and fax number):_____________________

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