Decedent is
☐ Resident
☐ Non-Resident
of City/County of Death

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH
OFFICE OF THE CHIEF MEDICAL EXAMINER
NORTHERN DISTRICT
6600 NORTHSIDE HIGH SCHOOL ROAD
ROANOKE, VIRGINIA 24019
PHONE (540) 561-6615, FAX (540) 561-6619
EMAIL OCME.WESTINV@VDH.VIRGINIA.GOV

WORKSHEET OF INVESTIGATION BY MEDICAL EXAMINER/INVESTIGATOR

☐ Presumed To Be

Decedent _____
First Name Middle Name Last Name Sr, Jr, III, etc

Home Address _____
Reported Homeless ☐ Number and Street City, State Zip

Age _____ **DOB** _____ **Sex** ☐ Male ☐ Female ☐ Unk **Occupation** _____

Race ☐ Black ☐ White ☐ Asian ☐ Native American ☐ Unknown ☐ Other _____

Hispanic Origin ☐ Yes ☐ No **SSN** _____

Marital Status ☐ D ☐ M ☐ NM ☐ W **SSN N/A** ☐

On the job? ☐ Yes ☐ No

MEDICAL EXAMINER AUTHORITY (Check only one)

☐ Sudden in apparent good health
☐ Unattended by physician
☐ Suspicious
☐ Unusual
☐ Suspected SIDS
☐ Violent or Unnatural
☐ In prison, jail or police custody
☐ City/County ☐ State ☐ Federal
☐ Patient/Resident of State Behavioral Health Facility

Scene Visit? ☐ Yes ☐ No
By ☐ LME ☐ MDI
Retrospective review? ☐ Yes ☐ No

Notification by _____ Date/Time _____ Official Title _____

Agency _____ Phone _____

Police Notified ☐ Yes ☐ No Investigator _____ Phone _____

Jurisdiction _____

	Date (MM/DD/YY)	Time (24h)	LOCATION	CITY/COUNTY	BY WHOM
LAST KNOWN ALIVE					
INJURY/ACUTE ILLNESS					
FOUND					
DEATH/PRONOUNCED					
EXAM OF BODY					

Cause of Death:

Autopsy: ☐ Yes ☐ No
Authorized By _____
Pathologist _____
Autopsy No _____
Location (if not OCME) _____

Manner of Death (check one only):
☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined ☐ Pending

I hereby declare that after receiving notice of the death described herein I took charge of the body and made inquiries regarding the cause and manner of death in accordance with § 32.1-283, Code of Virginia, and that the information contained herein regarding such death is correct to the best of my knowledge and belief.

_____ City of County of Appointment

_____ City of County of Appointment

_____ Date _____ Signature of OCME Investigator

_____ Date _____ Signature of Medical Examiner

_____ Name of OCME Investigator (Type or Print)

_____ Name of Medical Examiner (Type or Print)

MEANS OF DEATH

☐ **VEHICLE Status** ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Unknown ☐ Other _____

Type of vehicle associated with decedent ☐ Passenger car ☐ Pickup Truck ☐ Sport Utility ☐ Motorcycle
☐ Truck—more than 2 axles ☐ Bicycle ☐ Farm Vehicle ☐ ATV ☐ Moped ☐ Other _____

Devices (Mark applicable devices) ☐ Seat restraints used ☐ Airbag equipped ☐Airbag deployed
☐ Child restraint used ☐ Helmet used ☐ Other _____

How Injury Occurred (e.g. auto/truck collision) _____

Circumstances ☐ Skid/Yaw marks ☐ Speeding a factor ☐ Resulted in fire ☐ Resulted in drowning
☐ Weather related Road Conditions: _____

☐ **GUN** ☐ Handgun-caliber/make _____ ☐ Shotgun-gauge/make _____
☐ Rifle-caliber/make _____ ☐ Other _____ ☐ Unknown
Serial # _____

☐ **INSTRUMENT** ☐ Blunt ☐ Sharp ☐ **Description** _____

☐ **POISONING** ☐ Alcohol ☐ Drugs ☐ Carbon Monoxide ☐Others _____

☐ **DROWNING** ☐ Flotation device _____ Swimmer ☐ Y ☐ N ☐ Unk ☐ N/A Lifeguard present ☐ Y ☐ N ☐ Unk ☐ Boat Activity _____

☐ **ASPHYXIA** _____

☐ **FIRE** Suspected Cause _____ Smoke Detector ☐ Y ☐ N Operational ☐ Y ☐ N

☐ **FALL/JUMP** From _____ to _____ Approximate distance _____ feet

☐ **OTHER** _____

SURVEILLANCE FOR CIRCUMSTANCES OF DEATH (check all that apply)

Known Circumstances

☐ Death Related to Declared Emergency ☐ Feticide ☐ Hunting Incident ☐ Homicide/Suicide Event ☐ Police Involved
☐ Prisoner Death ☐ Pregnancy within 1 year ☐ Sports/Athletics ☐ Terrorism/Bioterrorism

Alleged Circumstances

☐ Child Abuse/Neglect ☐ Domestic Violence ☐ Elder Abuse/Neglect

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LOCATION DESCRIPTION

INJURY/ACUTE ILLNESS _____
☐ Inside ☐ Outside Description of place of injury/acute illness (Ex. apartment bathroom, hotel pool, etc.)

DEATH _____
☐ Inside ☐ Outside Description of place of death (Ex. hospital ER, ditch next to interstate, etc.)

MEDICAL HISTORY

☐ none known ☐ alcoholism ☐ cirrhosis ☐ hepatitis ☐drug abuse ☐asthma ☐ bronchitis ☐emphysema
☐ seizure disorder (cause) _____ ☐cancer _____ ☐diabetes ☐hypertension ☐atherosclerosis ☐stroke
☐ psychiatric diagnosis _____ ☐ depression ☐ dementia _____ ☐smoking
☐ recent trauma (specify) _____ ☐ hip fracture ☐ organ/tissue donor
☐ acute infections _____ ☐ HIV/AIDS ☐ other _____
☐ If suspected SIDS: Position when laid down _____ Position when found _____

MD/Institution _____ Phone # _____
MD/Institution _____ Phone # _____
Medications _____

MED-X Criteria (Possible Disease of Public Health Importance): Symptoms within 72 hours of death
☐ acute flaccid paralysis ☐ diarrhea ☐ mental status change/seizures ☐ fever ☐ jaundice ☐ rash
☐ unexplained death <50 years old

Additional Medical History:

When no autopsy send toxicology ☐ blood ☐ urine ☐vitreous ☐other _____
(If toxicology specimens are unobtainable, call your local district office for advice.) ☐ embalmed?
If death circumstances = MV driver then send both blood and vitreous specimens when possible.
If death circumstances = possible drug overdose & **NO** autopsy is planned then send **TWO** tubes of postmortem blood
If death circumstances = hospital survival then obtain admission blood sample or consult district office to allow opportunity to obtain admission sample

Decedent _____

View of Body by Medical Examiner

Date of Exam _____

Time of Exam _____

Name of Decedent _____ Location of Exam _____

Description of Body ☐ Clothed ☐ Unclothed ☐ Partly Clothed

List Clothing _____

List Personal Effects _____

Height _____ in. ☐ estimated **Weight** _____ lb. ☐ estimated

Hair color _____ **Eye color** _____ **Pupils R** _____ **L** _____ **Beard** _____ **Mustache** _____

Body Heat ☐ Warm ☐ Cold ☐ Ambient ☐ Refrigerated ☐ Other _____ **Temp** ◦**F** _____ Time _____

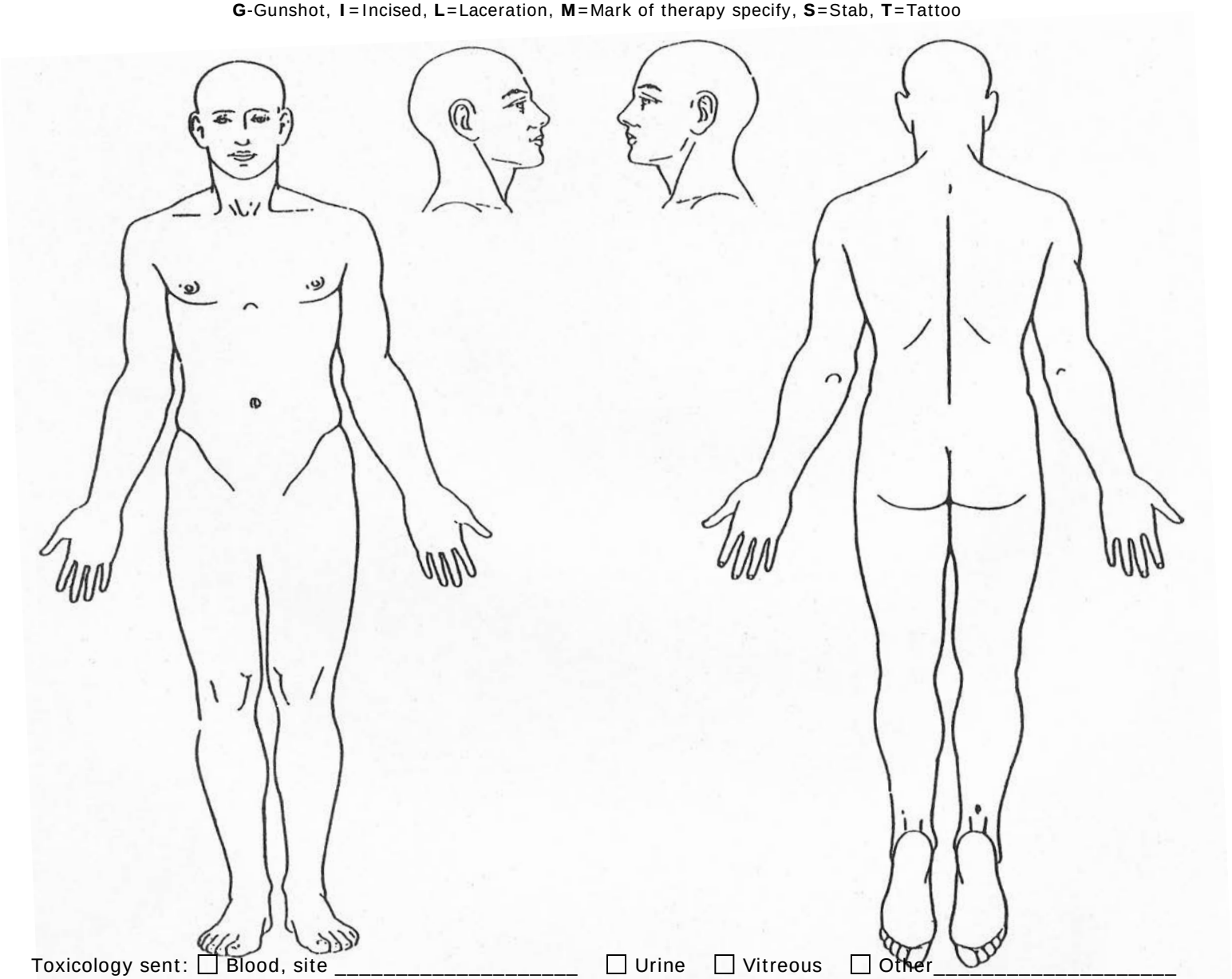
Rigor ☐ Complete ☐ Jaw ☐ Neck ☐ Arms ☐ Legs ☐ Passing ☐ Absent ☐ Embalmed ☐ Other _____

Livor ☐ Blanches ☐ Fixed **Color** ☐ Purple ☐ Pink/Red ☐ Indeterminate ☐ Other _____

Livor Location ☐ Anterior ☐ Posterior ☐ Left ☐ Right ☐ Regional (specify) _____

Decomposition ☐ No ☐ Yes ☐ Bloat ☐ Purge ☐ Skin Discoloration ☐ Blisters ☐ Skin Sloughing ☐ Insect Activity

Exam: Mark wounds and medical therapy on body diagram: A=Abrasion, **B**=Burn, **C**=Contusion, **F**=Fracture, **G**-Gunshot, **I**=Incised, **L**=Laceration, **M**=Mark of therapy specify, **S**=Stab, **T**=Tattoo



Toxicology sent: ☐ Blood, site _____ ☐ Urine ☐ Vitreous ☐ Other_____

Cause of Death _____ Manner of Death _____

ME (Print) _____ ME Signature _____

Send photos to ocme.westinv@vdh.virginia.gov

Narrative Description of Circumstances Surrounding Death:
(Describe the who, what, where, when and how the death occurred.)

Information obtained from:_____

Decedent _____ Date _____

Death Scene Investigation Report‡

Decedent _____
First Name Middle Name Last Name (Sr, Jr, III, etc)

Scene Location/Address _____ **Scene Premises** _____

Lead/On-Scene Investigation Officer _____ **Jurisdiction** _____

Date/Time ME Arrival _____ / _____ **Date/Time ME Departed** _____ / _____
Date 24 hr time Date 24 hr time

Scene Temp _____ °F **Time** _____ **Decedent's Temp** _____ °F **Time** _____

Temperature taken ☐ oral ☐ rectal ☐ axilla ☐ other _____

Description of Body ☐ Clothed ☐ Unclothed ☐ Partly Clothed

List Clothing/Effects:

Height _____ in. ☐ estimated **Weight** _____ lb. ☐ estimated

Hair color _____ **Eye color** _____ **Pupils** R ___ L ___ **Beard** _____ **Mustache** _____

Body Heat ☐ Warm ☐ Cold ☐ Ambient ☐ Refrigerated ☐ Other _____

Rigor ☐ Complete ☐ Jaw ☐ Neck ☐ Arms ☐ Legs ☐ Passing ☐ Absent ☐ Embalmed ☐ Other _____

Livor ☐ Blanches ☐ Fixed **Color** ☐ Purple ☐ Pink/Red ☐ Indeterminate ☐ Other _____

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☐ **Photos taken by whom** _____ ☐ **Copies requested for OCME?** Send digital photos to OCME investigator:

Central Virginia ocme.centinv@vdh.virginia.gov; Northern Virginia ocme.novainv@vdh.virginia.gov;
Eastern Virginia ocme.tideinv@vdh.virginia.gov; Western Virginia ocme.westinv@vdh.virginia.gov

SCENE DESCRIPTION

_____ _____ _____
Medicolegal Investigator Signature of Medical Examiner Date

Commonwealth of Virginia
Department of Health
Office of the Chief Medical Examiner

Decedent _____

Name of ME/Investigator (circle) _____

Signature of ME/Investigator (circle) _____

Death Scene Investigation Report
Scene Diagram‡

NOT DRAWN TO SCALE

‡Payment for death scene visit requires completion of both the Scene Investigation and Diagram pages