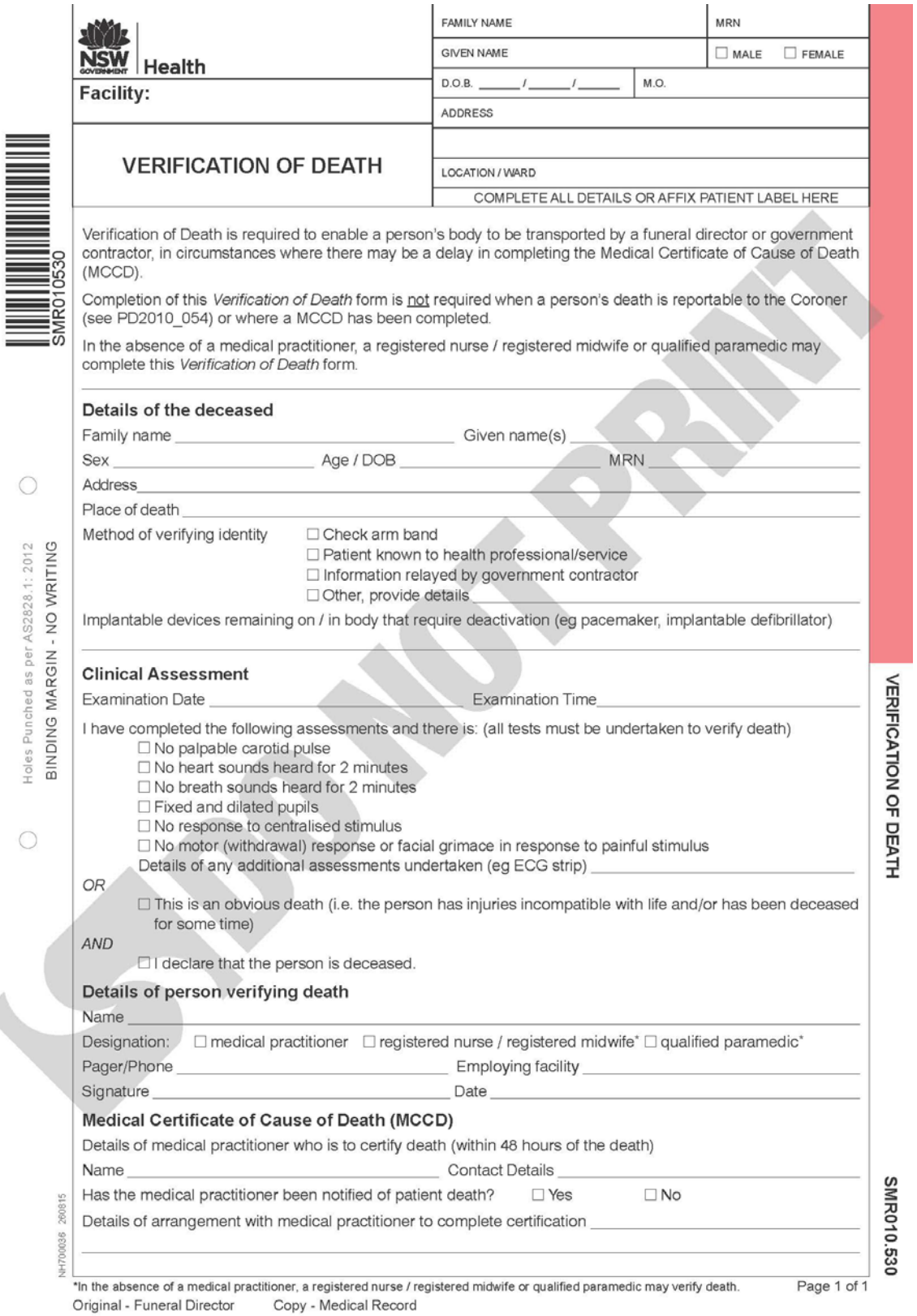
3.2 Verification of Death form SMR010530



NSW Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

SMR010530

VERIFICATION OF DEATH

Verification of Death is required to enable a person's body to be transported by a funeral director or government contractor, in circumstances where there may be a delay in completing the Medical Certificate of Cause of Death (MCCD).

Completion of this *Verification of Death* form is not required when a person's death is reportable to the Coroner (see PD2010_054) or where a MCCD has been completed.

In the absence of a medical practitioner, a registered nurse / registered midwife or qualified paramedic may complete this *Verification of Death* form.

Details of the deceased

Family name _____ Given name(s) _____

Sex _____ Age / DOB _____ MRN _____

Address _____

Place of death _____

Method of verifying identity
- ☐ Check arm band
- ☐ Patient known to health professional/service
- ☐ Information relayed by government contractor
- ☐ Other, provide details _____

Implantable devices remaining on / in body that require deactivation (eg pacemaker, implantable defibrillator)

Clinical Assessment

Examination Date _____ Examination Time _____

I have completed the following assessments and there is: (all tests must be undertaken to verify death)
- ☐ No palpable carotid pulse
- ☐ No heart sounds heard for 2 minutes
- ☐ No breath sounds heard for 2 minutes
- ☐ Fixed and dilated pupils
- ☐ No response to centralised stimulus
- ☐ No motor (withdrawal) response or facial grimace in response to painful stimulus

Details of any additional assessments undertaken (eg ECG strip) _____

OR

- ☐ This is an obvious death (i.e. the person has injuries incompatible with life and/or has been deceased for some time)

AND

- ☐ I declare that the person is deceased.

Details of person verifying death

Name _____

Designation: ☐ medical practitioner ☐ registered nurse / registered midwife* ☐ qualified paramedic*

Pager/Phone _____ Employing facility _____

Signature _____ Date _____

Medical Certificate of Cause of Death (MCCD)

Details of medical practitioner who is to certify death (within 48 hours of the death)

Name _____ Contact Details _____

Has the medical practitioner been notified of patient death? ☐ Yes ☐ No

Details of arrangement with medical practitioner to complete certification _____

*In the absence of a medical practitioner, a registered nurse / registered midwife or qualified paramedic may verify death.

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Original - Funeral Director Copy - Medical Record

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NH700036 260815

VERIFICATION OF DEATH

SMR010.530