

3.2 Verification of Death form SMR010530



Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

| | | |
|---|--|---|
|  | FAMILY NAME | MRN |
| | GIVEN NAME | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE |
| Facility: | D.O.B. ____/____/____ | M.O. |
| <p style="text-align: center;">VERIFICATION OF DEATH</p> | ADDRESS | |
| | LOCATION / WARD | |
| | COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE | |

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 _____

VERIFICATION OF DEATH

SMR010.530