|  |  |
| --- | --- |
| **REASON FOR REFERRAL:** | Choose an item. |
| **DATE/TIME OF REFERRAL:** |  | **HOSPITAL:** | Choose an Item |
| **REFERRING DOCTOR:** |  | **CONTACT DETAILS:** |  |
| **ADMITTING CONSULTANT:** |  | **CONTACT DETAILS:** |  |
| **DUTY CONSULTANT: (if applicable)** |  | **CONTACT DETAILS:** |  |
| **HAVE YOU SEEN THIS PATIENT ALIVE? IF NOT,****PLEASE SAY WHO HAS** |  |
| **IF YOU HAVE NOT SEEN THE PATIENT ALIVE, YOU CANNOT COMPLETE A DEATH CERTIFICATE** |

|  |  |
| --- | --- |
| **NAME OF DECEASED:** |  |
| **NHS NUMBER:** |  |
| **DATE OF BIRTH:** |  | **Occupation (If known):** |  | **SEX:** |  |
| **HOME ADDRESS (include****e postcode):** |  |
| **DATE ADMITTED TO** **HOSPITAL:** |  | **TIME OF ADMISSION:** |  |
| **DATE OF DEATH:** |  | **TIME OF DEATH:** |  |
| **PLACE OF DEATH:** |  | **DR PRONOUNCING DEATH:** |  |

|  |  |
| --- | --- |
| **PRESENTING** **COMPLAINT:** |  |
| **CIRCUMSTANCES OF DEATH AND PAST MEDICAL HISTORY (include details of any accident/incident):****Include other issues such as SUDIC, Organ Donation, Unnatural Death, Religious Issues**  |
|  |
| **WAS THE DECEASED SUBJECT TO A DEPRIVATION OF LIBERTY SAFEGUARDING ORDER (DoLS)? (indicate Yes/No)****IF YES, PLEASE PROVIDE DETAILS** |  |

|  |  |
| --- | --- |
| **IS A PACEMAKER PRESENT?** | Choose an item. |
| **IF YES, TYPE OF PACEMAKER:** |  |
| **NAME OF THE HOSPITAL WHO** **INSERTED THE PACEMAKER:** |  |

|  |  |
| --- | --- |
| **CONTACTS:** |  |
| **NEXT OF KIN:** |  |
| **RELATION TO DECEASED:** |  | **TEL NO:** |  |
| **ADDRESS (if different to above):** |  | **INFORMED OF REFERRAL:** |  |
| **POINT OF CONTACT (if****different to above)** |  | **TEL NO:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **FAMILY GP:** |  | **TEL NO:** |  |
| **ADDRESS:** |  |

|  |
| --- |
| **I WOULD BE WILLING TO ISSUE A MEDICAL CERTIFICATE GIVING THE CAUSE OF DEATH AS:** |
| **1A** |  |
| **1B** |  |
| **1C** |  |
| **2** |  |
| **DR / MR(S) - PRINT FULL NAME** |  | **CONTACT TEL NO:** |  |
| **GMC NUMBER** |  |