RECORD OF DEATH (and Notification of Death to the Coroner if required)

Hospital name:	**SURNAME:** **NHI No:** **OTHER NAMES:** **SEX : M / F AGE: DOB:** **ADDRESS:** (or attach patient label)

Date of death:		How long was the patient in hospital during this admission?		*Days / Hours / Weeks / Months*
Time of death: (24 hr clock)		How long was the patient in your care?		*Days / Hours / Weeks / Months*
Transferred from:		**Consultant:** (with whom you discussed this death)		

Did the patient undergo surgical or dental operation, or a medical procedure, or a procedure requiring anaesthesia, during this admission or prior to transfer?	**YES / NO**	Date and time of operation:	
If **YES** specify operation etc:			

Account of this admission (<50 words – please print clearly)

In your opinion, what was the cause of death?		*(circle one option)*	
Unknown cause, Suicide, Unnatural, etc	Was the death: without known cause / suicide / unnatural / violent / due to injury or was patient admitted due to injury? *(If YES, indicate which of the above applies)*	**YES**	**NO**
Medical/Dental treatment, Care, Pregnancy, Childbirth	Did the death occur during operation or procedure noted above?	**YES**	**NO**
	Does death appear to be result of that operation or procedure or other treatment?	**YES**	**NO**
	Did the death occur while the person was under anaesthetic (or does it appear to have been the result of administration of anaesthetic) ?	**YES**	**NO**
	Was the death while giving birth, or a result of being pregnant or giving birth?	**YES**	**NO**
Drugs and Alcohol	Was admission and/or death due to drug or substance abuse?	**YES**	**NO**
	Was patient detained in an institution under Alcoholism and Drug Addiction legislation?	**YES**	**NO**
Official Custody or Care	Was patient admitted from custody of Police / Prison / Security Officer?	**YES**	**NO**
	Was patient a child or young person in official custody or care?	**YES**	**NO**
	Was patient subject to compulsory treatment order under Mental Health legislation?	**YES**	**NO**
	Was patient in compulsory care under Intellectual Disability legislation?	**YES**	**NO**
Certificate	Are you/any medical practitioner prepared to sign a doctor's certificate *(BDM50)*?	**YES**	**NO**
Police	If not signing doctor's certificate *(BDM50)*, have the Police been notified?	**YES**	**NO**

Any response in the grey boxes means the death MUST be reported to the Coroner.
(If you are in any doubt or have any reservations about this death please discuss the matter with the Coroner.)

Are you aware of:-

(a). Any person expressing concern as to cause of death or hospital treatment of the deceased?	**YES**	**NO**
(b). Any reason (such as ethnic origins, social attitudes or customs, or spiritual beliefs) the requirement of a post-mortem examination might cause distress to persons connected with the deceased?	**YES**	**NO**
(c). Any member of deceased's family expressing the wish that a post-mortem should be performed?	**YES**	**NO**

Contact Details:	*Cellphone:*	*Locator:*	*Fax:*

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Reporting Medical Officer *(Please use capitals)* Signature *(must be medical practitioner)* Date & Time *(24 hr clock)*

For Hospital use only			**For Coroner's Use only**		
Faxed to Coroner?	☐ **YES**	☐ **NO**	*Discussed with Doctor?*	☐ **YES**	☐ **NO**
Received back from Coroner?	☐ **YES**	☐ **NO**	*Name of Doctor:*	*Time:*	
Clinical team notified of response?	☐ **YES**	☐ **NO**	*Coroner's Jurisdiction?*	☐ **YES**	☐ **NO**
GP Notified ?	☐ **YES**	☐ **NO**	*Post-mortem (subject to objection)?*	☐ **YES**	☐ **NO**
Family notified of death?	☐ **YES**	☐ **NO**	*Doctor's report in-lieu of PM?*	☐ **YES**	☐ **NO**
			Coroner:	Date:	Time: