|  |  |
| --- | --- |
| **Verification of death form for adult deaths (by non- medical clinicians)****In the community leave this form with relatives for Funeral Directors and ensure it is photographed and emailed to patients GP. If OOH advice needed contact HCP line 01865 903830.** **In Community Hospitals follow local procedure.****Copy of this form to be uploaded to correspondence on Carenotes.**  |  |
| **Expected** |  | **Unexpected** |  |  |
| **Time of death:** | HH | MM | **Date:** |  |  |
| **Patient location:** |  |  |
| **Patient details** |  |
| **NHS no.** |  | **Age** |  |  |
|  |  | **Sex** |  |  |
| **Date of birth:** | DD | MM | YYYY |  |  |
| **Full name:** |  |  |
| **Patient address:**  |  |  |
| **Next of kin:** |  |  |
| **Contact details:** |  |  |
| **GP name:** |  |  |
| **GP address:** |  |  |
| **The following criteria were present at (add time)**  | HH | MM | **Tick box** |  |
| Step 1 The patient has been in a collapsed state, with NO signs of life for a period of 15 minutes or more |  |  |
| Step 2 There are NO palpable carotid or femoral pulses for 1 minute |  |  |
| Step 3 There are NO cardiac sounds (listened with a stethoscope for 1 minute) |  |  |
| Step 4 There are NO signs of spontaneous respiration by observation over 5 minutes |  |  |
| Step 5 There are NO pupillary responses to light  |  |  |
| Step 6 NO response to trapezius squeeze  |  |  |
| An Advance decision uDNACPR has been authenticated (if applicable) |  |  |
| **Brief history of patient condition and any cardia devices in situ:** |  |
| **If known:** | **Burial** |  | **Cremation** |  |  |  |
| **Date GP contacted:** | DD | MM | YYYY | **Time:** | HH | MM |  |  |
| **Name of family member/friend present or contacted:** |  |  |
| **Name of the person completing this form (print):** | **Signature** | **Position** |  |
|  |  |  |  |