

NHS/Hospital No.: _____

Reference No.: _____ / _____ / _____
 (To be completed by medical examiner's office.)

Final Entry in Clinical Record Following a Death

The information provided in this form is confidential

The clinical information to be provided to a medical examiner or, where necessary, a coroner is prescribed by Regulations made under the Coroners and Justice Act 2009. It can be documented in the deceased person's clinical record or given on this form.

1. Name of deceased person and the date and time of death

Name: _____ (Forename) (Family name)	Date and time of death: ____ / ____ / ____ (Date) (Time)
---	---

2. Synopsis of circumstances, medical history and record of any external examination of the deceased person

This information must be documented before speaking with a medical examiner, coroner or one of their officers. Please include information about safeguarding concern, whether the deceased is subject of a Deprivation of Liberty Safeguarding (DoLS) or if a DoLS is pending an assessment.

continuation sheet

Death: Unexpected Sudden but not unexpected Expected Individualised end of life care plan

3. Implants, medical devices and communicable infections

Did the deceased person have any implants or medical devices? <input type="checkbox"/> Yes (as stated below) <input type="checkbox"/> No <i>Provide information based on review of records, external examination (if carried out) and / or discussion with relatives. Please specify the type of any implants or devices and the dates on which they were inserted.</i>	Communicable infections? <i>(If infectious, complete below)</i> <input type="checkbox"/> Inoculation / splash (blood-borne) <input type="checkbox"/> Aerosol (air-borne) <input type="checkbox"/> Ingestion <input type="checkbox"/> Contact ACDP Hazard Group (see guidance)
---	---

NHS/Hospital No.: _____

Reference No.: _____ / _____ / _____

(To be completed by medical examiner's office.)

1: 2: 3: 4:

4. Preliminary view of the cause of death (if formed)

This information must be documented before speaking with a medical examiner, coroner or one of their officers.

<i>(If no preliminary view can be formed before requesting advice, make a note of the reason.)</i>	Approximate interval between onset and death
1a _____	_____
1b _____	_____
1c _____	_____
2 _____	_____
_____	_____

5. Advice from medical examiner, coroner or their officers (if applicable)

If the death is apparently natural, please speak with a medical examiner/medical examiner's officer first— even if you are not an attending doctor.

Advice from medical examiner/examiner's officer	Advice from coroner/coroner's officer
Spoken with: _____	Spoken with: _____
Date and time: ____ / ____ / ____ at _____	Date and time: ____ / ____ / ____ at _____
Notes: _____ _____	Notes: _____ _____
	
Outcome: _____	Outcome: _____

6. Doctor's decision and action

Choose either A or B. If B is chosen, provide name of coroner's area and choose either B1 or B2. See guidance for reasons for a coroner's investigation.

A I have prepared a MCCD for confirmation by a medical examiner *(Only valid for a doctor that attended the deceased.)*

B I have **not** prepared a MCCD because the coroner for _____ **has agreed** to:

B1 investigate the death for the reason shown below *(i.e. request a post-mortem / hold an inquest)*

B2 refer the death to a medical examiner for certification *(for a natural death where I did not attend the deceased)*

A Medical Certificate of Cause of Death (MCCD) must not be issued for registration purposes until the cause of death has been formally confirmed by a medical examiner.

7. Medical practitioner's name and contact details

Full name *(print)*: _____ GMC No.: _____

Location/department: _____

Personal phone/bleep No.: _____ Alternative/out-of-hours contact No.: _____

Draft National Exemplar Form

This form may be used and evaluated by pilot areas working with the Department of Health to improve the process of death certification.

NHS/Hospital No.: _____

Reference No.: _____ / _____ / _____

(To be completed by medical examiner's office.)

Signature: _____	Date: ____ / ____ / ____
------------------	--------------------------

(The doctor providing the information in this form needs to be available to respond, if asked, to any enquiries from a medical examiner.)