

CONFIRMATION OF FACT OF DEATH

TO BE LEFT WITH THE DECEASED

| | |
|-----------------|--|
| NAME OF PATIENT | |
| ADDRESS | |
| DATE OF BIRTH | |
| OWN GP - NAME | |
| OWN GP- ADDRESS | |

| | |
|--|--|
| DATE OF CONFIRMATION OF DEATH | |
| TIME OF CONFIRMATION OF DEATH | |
| CONFIRMING QUALIFIED NURSE - NAME | |
| CONFIRMING QUALIFIED NURSE - SIGNATURE | |

| | |
|---|---|
| HAS THE DECEASED SEEN THEIR OWN GP IN THE LAST 14 DAYS | YES / NO |
| DOES THE PATIENT HAVE ANY IMPLANTABLE DEVICES, e.g. pacemaker or implantable cardioverter defibrillator (ICD) | YES - state type and position NO |
| DOES THE PATIENT HAVE ANY INFECTION | YES - state type NO |

THIS IS NOT A DEATH CERTIFICATE

Death certificates are obtained via the patient's own GP.