

REMOTE VERIFICATION OF DEATH IN CARE OR NURSING HOME

- 1) Date completed: Time:
- 2) Name of person completing form: Designated role:
- 3) Name of Deceased:
Date of Birth of Deceased:..... NHS Number of Deceased (if known):
- 4) Registered general practice:
- 5) Name and address of Care or Nursing Home:
..... POSTCODE:..... CONTACT NUMBER.....
- 6) Time of death or Time body discovered :
- 7) Were there any persons present at the time of death? YES /NO
If yes please give details (include name, relationship to deceased and contact telephone number):
.....
.....
.....
Continue on separate sheet if required
- 8) Was:
a) the death expected? YES /NO
b) DNACPR and/or ReSPECT Form in place? YES /NO
IF NO TO BOTH OF THESE, YOU SHOULD COMMENCE CPR AND TELEPHONE 999
- 9) Response to questions:
• No response to physical stimuli (pinch earlobe) YES /NO
• No signs of spontaneous respiration over 60 seconds YES /NO
• No pulse: palpating carotid or femoral pulse/pulse oximeter over 60 seconds YES /NO
• Pupils of both eyes fixed, dilated and unresponsive YES /NO
- 9) Signed: Print name:

Email this form, once completed, to deceased person's registered general practice.