NSW HEALTH

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION	

Facility:

REPORT OF DEATH OF A PATIENT TO THE CORONER
(FORM A)

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR010510

BINDING MARGIN - NO WRITING

PATIENT'S DETAILS

Patient's Surname: _____ **Given Names:** _____

Sex: (please tick) Male ☐ Female ☐ **Age:** _____ **Marital Status:** _____

Address: _____

NEXT OF KIN DETAILS

Next of Kin: _____ **Relationship:** _____

Address: _____

Telephone contact details: W: _____ **H:** _____ **M:** _____

SYNOPSIS OF CLINICAL NOTES

Date admitted: _____/_____/20___ **Time of admittance** (24 hour clock) _____

Date of death: _____/_____/20___ **Time of death** (24 hour clock) _____

History (Including relevant past history): _____

Examination on admission (Including evidence of any injuries, consumption of drugs or other relevant clinical findings): _____

_____

Treatment and subsequent progress: _____

Opinions as to cause of death (Include whether you believe the cause of death is a result of natural causes or other factors): _____

_____

Why has the case been referred to the Coroner?: _____

Have any antemortem specimens been taken and/or stored that you are aware of? (If so, please provide detail.): _____

_____

Are there any specific issues which need addressing at autopsy?: _____

_____

List results of any discussion with Next of Kin (e.g. was the Next of Kin informed that this is a Coroner's case? Is the Next of Kin satisfied with the treatment? Does the Next of Kin object to an autopsy?): _____

Are the results of any potentially relevant tests awaited? If yes, please specify: _____

_____

Additional comments: _____

_____

_____

_____

I (print name) _____ a registered Medical Practitioner **or** a registered Nurse/ Midwife* in the state of New South Wales hereby certify that at _____ time (24 hour clock) on _____ date (day, month and year), I examined the body of the above named patient and pronounced life extinct.

Your relationship to the deceased e.g. treating practitioner or nurse unit manager of ward: _____

CONTACT DETAILS OF CLINICIAN COMPLETING FORM

Please print

Work Address: _____

Work telephone number:_____ **Mobile telephone number:**_____ **Pager number:**_____

Signature:_____ **Qualifications:** _____ **Date:**_____/_____/ 20____

***Only to be completed by an RN in circumstances outlined in PD2005_488 Death - Extinction of Life and the Certification - Assessment TO THE CORONER**

NH606180 - 050510

REPORT OF DEATH OF A PATIENT TO THE CORONER (FORM A) SMR010.510