

Person's Name:

Sticker

Hospital / Hospice No:

SECTION 3: CARE AFTER DEATH		
Verification of death		
There have been none of the vital signs below forminutes		
➤ No signs of spontaneous respiration	<input type="checkbox"/>	
➤ No palpable pulses, carotid, femoral or radial	<input type="checkbox"/>	
➤ The pupils are fixed and widely dilated	<input type="checkbox"/>	
➤ No heart sounds	<input type="checkbox"/>	
Date of Death:	Recorded time of death:	
Death verified by: Nurse <input type="checkbox"/> or Doctor <input type="checkbox"/>	Confirmed (Doctor) <input type="checkbox"/>	
Name:	Signature:	
Staff members present at time of death:		
Relatives or Carers present:		
If not, has anyone been notified?	Y	N
Name of person informed:	Relationship to deceased:	
Contact number:		
Was it a good and peaceful death?		
Staff:	Y	N
Family:	Y	N
As per family feedback	Y	N
Remarks:		
Are the police likely to be involved?	Y	N
Does the person have a pacemaker /ICD?	Y	N
Care of the body:		
Performed according to Institutional policy with regard to		
➤ Treated with respect and dignity	Y	N
➤ Procedures and packing (including infection risk)	Y	N
➤ Cultural rituals / Spiritual / Religious needs met?	Y	N
➤ Person's valuables and belongings	Y	N

