NOTIFICATION OF ANTICIPATED DEATH AT HOME

Copies to:

☐ Funeral Director

Name: ____

Address: ____

Fax#: __________________________ Ph#: ________________________

☐ Office of the Chief Medical Examiner Fax#: (204) 945-2442

☐ Physician/Nurse Practitioner patient's health record

☐ Local Police Department or RCMP Detachment Fax#: ______________
Department/Detachment name: ________________________________

☐ Home Care Case Coordinator (if registered with Home Care)

☐ Patient (place in prominent location in the home)

☐ Palliative Care Program (if registered with Palliative Care)

This notice is being sent to the recipients listed above in anticipation of the death at home of my patient. Goals of care for this patient are clearly defined and do not include resuscitation. The personal particulars of my patient are as follows:

Last Name:	First Name:
Date of Birth (month in words):	Sex: ☐ Male ☐ Female
MHSC:	PHIN:
Street Address or Specific Rural Address (not Box #):	

As attending physician/nurse practitioner, I or my designate will be responsible for completing the Medical Certificate of Death within the required 48 hours.

Printed Name of Physician/ Nurse Practitioner:	Signature:
Address:	
Ph#:	Fax#:
Physician Designate (printed):	
Address:	
Ph#:	Fax#: