Southern Health Santé Sud

NOTIFICATION OF DEATH

PHYSICIAN OR NURSE: COMPLETE PARTS A & B

A. PRONOUNCEMENT, NOTIFICATION AND AUTOPSY

DATE OF DEATH: ____________ (DD/MM/YYYY) TIME OF DEATH: ________ (24 HOUR) DEATH PRONOUNCED BY: ____________ (PRINT NAME AND PROFESSIONAL DESIGNATION)

DATE/TIME OF DEATH IS (*check one*): ☐ Actual Date/Time of Death **OR** ☐ Date/Time Death Pronounced

1.	**Patient has Internal Cardioverter Defibrillator?**	☐ YES	☐ NO	If "YES indicate if: ☐ Deactivated ☐ Active
2.	**Patient has a pacemaker**	☐ YES	☐ NO	If yes is selected for any of these 3 items
3.	**Patient was a Radionuclide Therapy Patient?**	☐ YES	☐ NO	Funeral Home Informed ☐ YES ☐ NO

NAME OF PRIMARY CARE PROVIDER: ____________
DATE NOTIFIED: ____________ (DD/MM/YYYY) TIME: ________ (24 HOUR)

NAME OF PREFERRED CLAIMANT: ____________ Relationship: ________
DATE NOTIFIED: ____________ (DD/MM/YYYY) TIME: ________ (24 HOUR)

NAME OF OTHER FAMILY/PERSON: ____________ Relationship: ________
DATE NOTIFIED: ____________ (DD/MM/YYYY) TIME: ________ (24 HOUR)

IF DEATH OCCURRED IN ACUTE CARE
RESIDENT OF PERSONAL CARE HOME: ☐ YES ☐ NO ____________ (NAME OF PERDSONAL CARE HOME)

PERSONAL CARE HOME NOTIFIED: ☐ YES ☐ NO DATE: ________ (DD/MM/YYYY) TIME: ________ (24 HOUR)

AUTOPSY: Discussed with Preferred Claimant ☐ YES ☐ NO PREFERRED CLAIMANT REQUESTED AUTOPSY ☐ YES ☐ NO
AUTOPSY CONSENT FORM COMPLETED ☐ YES ☐ NO NECROPSY CLINICAL DATA FORM COMPLETED ☐ YES ☐ NO

A REPORTABLE DEATH DOES <u>NOT</u> MEAN THAT AN AUTOPSY WILL BE PERFORMED

PART A COMPLETED BY: ____________ (PRINT NAME) ____________ (SIGNATURE AND PROFESSIONAL DESIGNATION)

B. CHECKLIST FOR DEATHS THAT ARE REPORTABLE TO THE MEDICAL EXAMINER'S OFFICE: Answer all questions (as required by *The Fatality Inquiries Act of Manitoba*).

An inquiry into a death is to be conducted if it appears that the death occurred:

a	Due to an accident;	☐ YES	☐ NO
b	By suicide or homicide;	☐ YES	☐ NO
c	Suddenly and unexpectedly when the deceased appeared to be in good health;	☐ YES	☐ NO
d	Due to poisoning;	☐ YES	☐ NO
e	Due to contagious disease that is a threat to public health;	☐ YES	☐ NO
f	During pregnancy, or following pregnancy in circumstances that might reasonably be related to pregnancy;	☐ YES	☐ NO
g	In any of the following circumstances: i. During surgery or the performance of an invasive medical procedure, ii. Within 10 days after the surgery or performance of an invasive medical procedure, iii. While the deceased is under anesthesia;	☐ YES	☐ NO
h	Within 24 hours after the deceased attends at a hospital seeking admission ;	☐ YES	☐ NO
i	While the deceased is in the custody of a peace officer or as the result of the use of force by a peace officer who was acting in the course of duty;	☐ YES	☐ NO
j	As a result of: i. Contracting a disease or condition, ii. Sustaining an injury, or iii. Exposure to a toxic substance at the deceased current or former place of employment or business;	☐ YES	☐ NO
k	While the deceased is a resident in a facility under *The Mental Health Act* or a development Centre under *The Vulnerable Persons Living with a Mental Disability Act;*	☐ YES	☐ NO
l	While the deceased is imprisoned or detained in a correctional facility, jail or penitentiary;	☐ YES	☐ NO
m	When the deceased is a child;	☐ YES	☐ NO
n	In a prescribed type or class of facility or institution;	☐ YES	☐ NO
o	In prescribed circumstances.	☐ YES	☐ NO

PART B COMPLETED BY: ____________ (PRINT NAME) ____________ (SIGNATURE & PROFESSIONAL DESIGNATION)

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NURSE / DESIGNATE: COMPLETE PARTS C to F

C. DEATH IS REPORTABLE TO MEDICAL EXAMINER'S OFFICE (phone #: 1-204-945-2088) ☐ YES ☐ NO

MEDICAL EXAMINER OFFICE NOTIFIED ☐ YES ☐ NO DATE: ______ (DD/MM/YYYY) TIME: ______ (24 HOUR)

MEDICAL EXAMINER ORDERED AUTOPSY ☐ YES ☐ NO Name: ______ (MEDICAL EXAMINER WHO ORDERED AUTOPSY)

Name: ______ (PRINT NAME OF MEDICAL EXAMINER/DELGATE) Signature: ______ (SIGNATURE OF MEDICAL EXAMINER/DELEGATE)

DATE: ______ (DD/MM/YYYY) TIME: ______ (24 HOUR)

MEDICAL EXAMINER/DELEGATE REMOVED MEDICAL CERTIFICATE OF DEATH FROM HOSPITAL ☐ YES ☐ NO

COMMENTS: ______

D. TISSUE DONATION (phone #: 1-866-366-6778)

TISSUE BANK MANITOBA NOTIFIED : DATE: ______ (DD/MM/YYYY) TIME: ______ (24 HOUR)

MEETS TISSUE BANK CRITERIA: ☐ YES ☐ NO

CANDIDATE: ☐ YES ☐ NO RECOVERY COMPLETE: ☐ YES ☐ Unknown

NAME OF TISSUE TRANSPLANTATION COORDINATOOR:

E. PERSONAL BELONGINGS

PERSONAL BELONGINGS TO: ☐ Preferred Claimant ☐ Police ☐ Housekeeping ☐ Left on Body ☐ Other: ______

☐ Dentures ☐ Glasses ☐ Hearing Aid(s) ☐ Other: ______

VALUABLES TO: ☐ Preferred Claimant ☐ Police ☐ HIS or Business Office ☐ Left on Body ☐ Other: ______

List valuable Items **(e.g. money, jewellery):** ______

PART E COMPLETED BY: ______ (PRINT NAME) ______ (SIGNATURE & PROFESSIONAL DESIGNATION)

F. RELEASE OF BODY

☐ Release of Body by Medical Examiner ☐ Not Applicable
☐ Autopsy requested ☐ Not Applicable
☐ Release of Body by Tissue Bank Manitoba ☐ Not Applicable

If one of these is applicable:
DATE: ______ (DD/MM/YYYY) TIME: ______ (24 HOUR)

BODY RELEASED TO: SIGNATURES

☐ Funeral Home: ______ (PRINT NAME) ______ (I , THE ABOVE SIGNED, AM AUTHORIZED BY THE PREFERRED CLAIMANT TO CALL FOR THE REMAINS AND BELONGINGS OF THE DECEASED)

☐ University of Man.: ______ (PRINT NAME) ______ (I , THE ABOVE SIGNED, AM AUTHORIZED BY THE PREFERRED CLAIMANT TO CALL FOR THE REMAINS AND BELONGINGS OF THE DECEASED)

☐ Other: ______ (PRINT NAME) ______ (I , THE ABOVE SIGNED, AM AUTHORIZED BY THE PREFERRED CLAIMANT TO CALL FOR THE REMAINS AND BELONGSINGS OF THE DECEASED)

On behalf of: ______ (PRINT NAME)

I, the undersigned, have confirmed that the body is ready to be released and witness the signature of the person to whom the body is released to:

______ (PRINT NAME)

______ (SIGNATURE AND PROFESSIONAL DESIGNATION IF APPLICABLE) DATE: ______ (DD/MM/YYYY) TIME: ______ (24 HOUR)