SMR010509

Holes punched as per AS2828.1:2012

BINDING MARGIN - NO WRITING

PART ONE – ELIGIBILITY AND SCREENING

This form must be completed by a doctor who is required, under Section 39 of the *Births Deaths and Marriages Act (1995)*, to notify the Registrar of Births, Deaths and Marriages of a death (see Statutory Requirements on p4 of this form). This form is not to be used in the case of a perinatal death (person up to 28 days of age). Use Medical Certificate of Cause of Perinatal Death.

1. Did this death occur under or as a result of, or did it occur within 24 hours of the administration of an anaesthetic or sedative drug administered in the course of a medical, surgical or dental operation or procedure or other health related procedure?

☐ **Yes** - this death must be reported to SCIDUA on form SMR010.511 Report of Death Associated with Anaesthesia/Sedation (Form B). **Go to question 2**

☒ **No - go to question 2**

2. For all public and private hospital inpatients you must complete the NSW Coronial Checklist (SMR010.513). Have you completed this checklist?

☐ **Yes**

☒ **No**

3. Is this death a reportable death in accordance with Sections 6, 23, 24 or 38 of the *Coroners Act (2009)*? *Note: definitions of reportable deaths are included on page 4 under the 'Statutory Requirements".*

☐ **Yes** - report this death to the Coroner on form SMR010.510 "Report of Death to the Coroner Form A. Do not complete this Medical Certificate of Cause of Death

☒ **No - go to question 4**

4. Did the person die in circumstances where death was not the reasonably expected outcome of a health related procedure carried out in relation to that person? *Refer to Section 6(3) of the Coroners Act (2009) for the definition of a 'health related procedure'.*

☐ **Yes** - report this death to the Coroner on form SMR010.510 'Report of a Patient Death to the Coroner (Form A)'. Do not complete this Medical Certificate of Cause of Death

☒ **No - go to question 5**

5. Was the deceased pregnant within six weeks of the death?

☐ **Yes - go to question 7**

☒ **No - go to question 6**

6. Was the deceased pregnant between six weeks and 12 months of the death?

☐ **Yes - go to question 7**

☒ **No - go to question 7**

7. Please advise how you can accurately state the cause of this death?

☒ I cared for the patient in the six months before death. Specify the date last seen alive by you 09/07/2018

☐ I have not cared for this patient in the six months before death. I have referenced the cause of death with the health care record of the deceased and I have examined the body of the deceased on / /

Note: if you have not cared for the patient in the six months before death and you have not viewed the body of the deceased and you have not referenced the health care record and there is no other doctor available who has, you must NOT complete this Medical Certificate of Cause of Death. You must refer this death to the Coroner. If you complete this certificate you may be in breach of Section 38 of the Coroners Act (2009). Refer to page 4.

8. Is this certificate issued pursuant to Section 38(2) of the *Coroners Act (2009)*? Refer to page 1. ☐ **Yes** ☒ **No**

9. Are you a relative of the deceased?

☐ **Yes** – you may only complete this certificate if you are the only doctor in a remote area ☒ **No**

10. Did the deceased undergo an operation or procedure within 4 weeks of death? ☐ **Yes** ☒ **No**

If YES, specify type of operation _____

PART TWO – DETAILS OF DECEASED USE BLOCK LETTERS ONLY

11. Family name

STEVENS

12. Given name(s)

NANCY SHIRLEY

13. Date of death

10/07/2018 or between / / and / /

14. Date of birth 29/11/1928

15. Age of deceased 089 Years

16. Sex of deceased ☐ Male ☒ Female

17. Country of Birth

18. Place of death

Name of place/institution (if applicable) TALLWOODS CORNER AGED CARE

Street no. and name 1 MYRA STREET

Suburb/Town WAHROONGA State NSW Country AUSTRALIA Postcode 2076

19. Address of usual residence of deceased ☒ **as above**

Name of place/institution (if applicable)

Street no. and name

Suburb/Town State Country Postcode

If this person was a resident of, or died in a correctional facility, police station, detention centre, mental health facility or a disability care facility the death is reportable – refer to page 4.

20. Was the deceased of Aboriginal or Torres Strait Islander origin?

☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☒ Neither ☐ Not known

NH606699 140815

Family name..... Given name(s)..... DOB..... Sex..... MRN.....

PART THREE – CAUSE OF DEATH USE BLOCK LETTERS ONLY

PLEASE PRINT CLEARLY, DO NOT ABBREVIATE

21.1		Description of disease or condition	Approximate duration between onset & death
Disease or condition directly leading to death. Do not only state the mode of dying such as cardiac or respiratory failure without also stating antecedent causes.	a)	UTI C DEHYDRATION	
		DEMENTIA Due to	
Antecedent causes Note. If the direct cause of death as described in line a) was due to, or arose as a consequence of another disease, injury or condition, this should be reported in line b). Similarly, if the condition on line b) was due to another condition, report this on line c) and so forth.	b)	HYPERTENSION	
		TIA - SEIZURE Due to	
	c)	FALLS	
		Due to	
	d)		

21.2	Description of disease or condition	Approximate duration between onset & death
Other significant conditions contributing to the death but not related to the disease, injury or condition causing it.		

PART FOUR – DOCTOR'S DETAILS AND DECLARATION USE BLOCK LETTERS ONLY

22. Family name

MACHADO

23. Given name(s)

ROLAND

24. Business address

Business Name: BEECROFT GENERAL PRACTICE

Street no. and name: 8A 6-8 HANNAH STREET

Suburb/Town: BEECROFT State: NSW Postcode: 2119

25. Daytime telephone number

02 9484 1552

26. Work mobile telephone number

27. Work email address

28. What is your Australian Health Practitioner Regulation Agency (AHPRA) Registration Number?

MED0001194250

29. Did you acquire or do you anticipate acquiring any property, pecuniary or other benefit(s) by reason of this death?

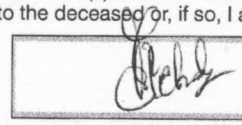
☐ Yes ☒ No

30. Have you notified the AMO and discussed the cause of death?

☐ Yes ☐ No ☒ N/A

31. I hereby certify that:

a) I am a currently registered medical practitioner,
b) I believe this individual is deceased and the death is not reportable to the Coroner and I am satisfied the identity of the deceased is as indicated in part two,
c) I was responsible for providing medical care to the deceased immediately before death or if not, I have examined the deceased after death and I have referenced the medical record,
d) The particulars and cause(s) of death recorded in this certificate are true to the best of my knowledge and belief,
e) I am not related to the deceased or, if so, I am the only doctor in a remote area.

Doctor's signature 

Designation GP

Date 10/07/2018

PART FIVE – LODGEMENT

Original white copy is required by the Registrar to be forwarded within 48 hours to the funeral director with the body to permit burial or other disposal of the deceased. The same original white copy is then required by the Registrar to be provided as a supporting document by the funeral director to the Registry of Births, Deaths and Marriages within 7 days after burial or other disposal of the deceased. Duplicate yellow copy for the health record.