NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

ATTENDING PRACTITIONER'S CREMATION CERTIFICATE

PUBLIC HEALTH REGULATION, 2012 Clause 81

SMR010520

My name is ..... *(Full name in block letters)*. I am a registered medical practitioner in Australia. I am informed that an application has been made or is to be made for the cremation of the remains of

..... *(Name of deceased)*

of ..... *(Last address of deceased)*.

I am the attending practitioner because:

I attended the person immediately before, or during, the illness terminating in their death;

OR

As no such practitioner is available, or it is not practical for them to issue the cremation certificate:

(i) I have reviewed the dead person's medical record, **AND**

(ii) I am a member of staff of the hospital where the death occurred, or work at the same general practice as a medical practitioner who attended the person immediately before, or during, the illness terminating in their death.

(cross out which does not apply above)

AND

I have seen the body after death and am satisfied as to the identity of the body.

1. State date and time of death .....

2. State place where the deceased died. (Give address and state whether own residence, lodgings, hotel, hospital, nursing home, etc)

.....

3. How soon after death did you examine the body? Days ..... Hours.....

4. Have you have previously cared for this patient? Yes / No

   If yes, when did you last see the deceased alive? (Insert date) .....

   If no, when did you review the deceased's records? (Insert date) .....

5. Cause of death

   (a) Has a Cause of Death Certificate been issued for the deceased? Yes / No

   (i) **If no**, an Attending Practitioners Cremation Certificate cannot be issued.

   (ii) **If yes**, are you the person who completed the cause of death certificate? Yes / No

   (b) In your view, is the cause of death as stated on the Cause of Death Certificate? Yes / No

   (i) **If no**, please state what you believe is the cause of death to be.....

   (ii) What was the duration of this condition in years, months, or days? .....

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NH606572 220313

ATTENDING PRACTITIONER'S CREMATION CERTIFICATE SMR010.520

NSW GOVERNMENT Health

Facility:

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6. Is the death reportable to the coroner under the Coroner's Act 2009? Yes / No

If yes, you must report this death to the Coroner. You must not complete this certificate for cremation.

If uncertain, please consider the following: Do you have reason to believe that the death of the deceased occurred under any of the following circumstances?

- Violence
- Unnatural cause
- Sudden death without apparent cause
- No medical practitioner review in the six months prior
- Unexpected outcome of a medical procedure
- Abuse or neglect
- Child (or their sibling) reported to Community Services
- A child in care
- Under the care of a mental health facility
- With disability requiring support service/s
- In police custody
- During a police operation
- Escaping custody

If the answer to any of the above is **yes**, the death should be referred to the Coroner and you should not complete this form.

Note: Section 5 of the NSW Policy Directive "Coroners Cases and the Coroner's Act" provides more detailed guidance for making this decision http://www0.health.nsw.gov.au/policies/pd/2010/PD2010_054.html.

7. Are you a relative of the deceased? Yes / No

If yes, state relationship .....

8. Have you, so far as you are aware, any pecuniary interest in or arising from the death of the deceased? Yes / No

If yes, what is that interest .....

9. Was any battery powered device attached to or present in the body of the deceased? Yes / No

If yes, what kind of device? .....

If yes, has it been removed? Yes / No

(If device is present, crematory authorities may decline to cremate the deceased as battery powered devices may explode during cremation)

10. To the best of your knowledge, has the deceased received any of the following radioactive treatments (tick if yes)?

Palliation for bone metastases

- Strontium-89 injection in the year before death ☐
- Samarium-153 injection in the 3 weeks before death ☐
- Rhenium-188 injection in the week before death ☐

Infusion for liver cancer or metastases

- Yttrium-90 or Rhenium-188 in the 2 weeks before death ☐

Injection for treatment of neuroendocrine tumours

- Lutetium-177 in the week before death ☐

Treatment for Thyroid cancer, endocrine tumours, or non-Hodgkin's lymphoma

- Iodine-131 (injection or oral) in the week before death ☐

Radioactive implant (permanent)

- Iodine-125 implanted in the year before death ☐

If yes to any, contact the Radiation Safety Officer at the treating institution for provision of required information to the crematorium.

Note: This form is required by the medical referee in order for them to issue a Cremation Permit.

I hereby certify that, to the best of my knowledge and belief and having sought where appropriate additional information, the information given above is true and accurate, and that no relevant information has been omitted.

Signature: ..... Date/Time: .....

Address: .....

Phone Number: ..... AHPRA Registration Number: MED .....

NO WRITING