Department of Health

CREMATION ACT 1929
Cremation Regulations 1954

Form 7 **(Reg. 12)**

Certificate of Medical Practitioner

Certificate to be completed by doctor who attended deceased prior to death.
Add additional pages if more space is required.
Attach copies of all relevant laboratory reports, results, certificates etc.

Deceased

Name

Address _____

Date of birth / / | Age

Marital status | ☐ Male ☐ Female

Occupation

Doctor

Name

Address _____

Are you a spouse, de facto partner or relative of the deceased?
☐ No
☐ Yes. Nature of relationship _____

As far as you are aware, do you have a pecuniary interest in the deceased's estate or any other pecuniary interest in the deceased's death?
☐ No
☐ Yes. Give details _____

Were you the deceased's usual doctor? ☐ No ☐ Yes

Recent care of deceased

During the 4 weeks prior to death did the deceased receive medical or nursing care?
☐ No
☐ Yes. Where was the deceased cared for?
- ☐ Hospital _____
- ☐ Nursing home _____
- ☐ Home _____
- ☐ Other _____

If cared for at home or other place, who provided care?
☐ Professional health care providers
☐ Relatives, friends, others
Give names and relationship to the deceased _____

Did you attend the deceased during his or her last illness?
☐ No ☐ Yes Since what date? / /20

Did any other doctor(s) attend the deceased during his or her last illness?
☐ No
☐ Yes. Give names _____

Last illness

Brief clinical history of last illness including diagnoses and events leading to death.

_____

_____

_____

Details of death

Date / /20 | Time a.m./p.m.

Place where the deceased died
☐ Home
Address _____
☐ Hospital _____
Address _____
☐ Other _____
Address _____

Details of death (cont'd)

Were you present when the deceased died?

☐ Yes

☐ No. When did you last see the deceased alive?

Date / /20 Time a.m./p.m.

Did you examine the deceased's body after death?

☐ No

☐ Yes. Give details _____

Do you have any reason to suppose that a further examination of the deceased's remains may be desirable?

☐ No

☐ Yes. Give details _____

Cause of death

(If a Medical Certificate of Cause of Death is attached, answers are not required to these questions.)*

Was a post mortem performed?

☐ No

☐ Yes. Give details of results _____

_____

*Did you sign the Medical Certificate of Cause of Death?

☐ Yes

☐ No. Name of the doctor who signed the certificate _____

*Direct cause of death _____

*Antecedent causes of death (if any) _____

*Conditions contributing to or accelerating death (if any) _____

Clinical observations

Do you know, or have reason to suspect, that the deceased's death was directly or indirectly due to any of the following? *(tick if yes)*

☐ violence ☐ poison

☐ privation or neglect ☐ medical procedure

☐ drowning ☐ suffocation

☐ burns

In view of the deceased's lifestyle and health, do you have any doubts about the character of the deceased's illness or cause of death?

☐ No

☐ Yes. Give details _____

Safety of cremation

At the time of death was the deceased fitted with a cardiac pacemaker?

☐ No

☐ Yes. Has it been removed ☐ Yes ☐ No

Had the deceased received any of the following radioactive treatments?

• Strontium-89 injection *(e.g. for bone metastases)* during the 12 months prior to death	☐ No	☐ Yes*
• Iodine-125 seed implant *(e.g. for prostate cancer)* during the 12 months prior to death	☐ No	☐ Yes*
• Samarium-153 during the 2 weeks prior to death	☐ No	☐ Yes*
• Rhenium-188 during the 2 weeks prior to death	☐ No	☐ Yes*
• Yttrium-90 during the 2 weeks prior to death	☐ No	☐ Yes*
• Iodine-131 during the week prior to death	☐ No	☐ Yes*

* If yes — has the Radiation Safety Officer at the treating institution certified that cremation is safe? ☐ No ☐ Yes

ATTACH CERTIFICATE

Are you aware of anything else that could render cremation unsafe? *(e.g. other medical devices, recent treatment etc.)*

☐ No

☐ Yes. Give details _____

Certification of medical practitioner

I certify that the information set out above is true and correct and that I have not omitted any relevant information.

Signature _____ Date / /20

Amended 2008