Non-Acute - Summary of Death Certification Page 1 of 2

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**Non-Acute - Summary of Death Certification**

*The information provided in this form is confidential*

**This form must be completed by a doctor that attended to the deceased during their last illness.**

1. **Name of deceased Details of death.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name - |  |  | Place of Death:  Date of Death:  Time of Death:  Death Verified by:  NOK Name and Contact Number: |  |  |
|  |  |
|  |  |  |  |  |  |

1. **Brief circumstances and proposed cause of death**

*This information is to provide brief information to support your proposed cause of death or referral to the coroner. Please include information regarding any concerns raised.*

|  |  |  |
| --- | --- | --- |
| *continuation sheet* | | |
| Do you have any concerns about the quality of care this patient received? Yes No *If ‘yes’ please detail above* | | |
|  | | Approximate interval |
|  |  | between onset and death |
| 1a: |  |  |
| 1b: |  |  |
| 1c: |  |  |
| 2: |  |  |
|  |  |  |

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Figure

|  |  |
| --- | --- |
| NHS No.: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ | Reference No.: \_ \_ \_ \_ \_ / \_ \_ \_ \_ \_ \_ / \_ \_ \_ \_ |
|  | *(To be completed by medical examiner’s office.)* |

1. **Doctor’s decision and action**

I feel able to complete the MCCD with no need for coroner referral *(Only valid for a doctor that attended the deceased.)*

I feel this case requires referral to the coroner for further action for the following reason:

**A Medical Certificate of Cause of Death (MCCD) must not be issued for registration purposes until the cause of death has been formally confirmed to you by email from the Medical Examiner’s Office.**

1. **Medical Practitioner’s name and contact details**

*(The doctor providing the information in this form needs to be available to respond, if asked, to any enquiries from the Medical Examiner’s Office.)*

Date:

Name of Practice / Hospice:

Date last seen alive:

Direct Contact Number (avoiding switchboard):

E-Mail:

GMC No.:

Name:

Once completed please return to: [Medicalexaminers.office@stockport.nhs.uk](mailto:Medicalexaminers.office@stockport.nhs.uk)

**Please also attach a copy of the patient’s electronic summary of medical record.**

For any queries please contact the Medical Examiner’s Office on 0161 – 419 5773