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| **ELECTRONIC**  **DEATH**  **REFERAL**  **FORM**  **(EDRF)** | See the source image  **Samantha Marsh**  **Acting Senior Coroner for Somerset** |

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| **This report will be submitted to the Coroner for Somerset.**  **Please ensure accurate completion of all fields to the best of your knowledge and belief**  **Please return this form electronically to the Coroner by email to:** [**CoronersOfficersSomerset@avonandsomerset.pnn.police.uk**](mailto:CoronersOfficersSomerset@avonandsomerset.pnn.police.uk)  and copy in [**bereavementsupportoffice@somersetft.nhs.uk**](mailto:bereavementsupportoffice@somersetft.nhs.uk)  Tel: 01278 649700 for urgent enquiries |

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| **FULL NAME OF REFERRER** |  |
| **PLACE OF WORK ADDRESS**  **(HOSPITAL/SURGERY)** |  |
| **GRADE (if hospital Dr)** |  |
| **MOBILE NUMBER** |  |
| **EMAIL ADDRESS** |  |
| **SECONDARY CONTACT** \* A Coroner’s Officer may need to contact you to discuss this case further. In the event that you are not available please provide the contact details for a colleague who will be able to assist. |  |

**PATIENT DETAILS**

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| **FULL NAME** |  |
| **DATE OF BIRTH** |  |
| **HOME ADDRESS** |  |
| **GENDER** |  |
| **DATE OF ADMISSION** (if hospital death) |  |
| **HOSPITAL No:** (if applicable) |  |
| **NAME OF TREATING CONSULTANT** (if applicable) |  |

**DEATH / REFERRAL DETAILS**

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| **DATE OF DEATH** |  | |
| **TIME OF DEATH (24hr clock)** |  | |
| **PLACE OF DEATH** |  | |
| **WHO VERIFIED LIFE EXTINCT?** |  | |
| **CIRCUMSTANCES OF DEATH**  (if you are a GP, and there has been a recent hospital admission, please reference this) |  | |
| **PREVIOUS MEDICAL HISTORY**  (please advise if the patient has a pacemaker or ICD in situ) |  | |
| **REASON FOR REFERRAL**  **TO THE CORONER**  **(please select the**  **relevant option)** | Unknown cause of death |  |
| the deceased was not seen by the certifying doctor either after death or within 28 days before death |  |
| Death related to any treatment or procedure of a medical or similar nature (including during an operation or before recovery from the effects of an anaesthetic) |  |
| Patient has recently suffered a fall or other kind of accident |  |
| Death is as a result of violence, trauma or physical injury, whether inflicted intentionally or otherwise |  |
| the death may be due to an industrial disease or related to the deceased’s employment (e.g mesothelioma) |  |
| Death occurred as a result self harm (i.e. potential suicide) |  |
| Death occurred as a result of neglect (including self neglect by the deceased) or failure of care by another person |  |
| Death occurred due to use of a controlled drug. Medicinal product or toxic chemical |  |
| the death occurred during or shortly after state detention (i.e. prison or police custody), or any other form of police involvement |  |
| the death occurred while the deceased was subject to compulsory detention under the Mental Health Act |  |
| Other: |  |
| **FAMILY ISSUES / CONCERNS?** |  | |
| **CURRENT LOCATION OF DECEASED?** |  | |

**CAUSE OF DEATH**

|  |  |  |
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| **ARE YOU ABLE TO ISSUE THE MCCD?** | |  |
| **IF YES, PLEASE COMPLETE BELOW** | |  |
|  | | |
| **1a)** |  | |
| **1b)** |  | |
| **1c** |  | |
| **II)** |  | |
| \* please do not use abbreviations when recording the medical cause(s) of death | | |

**LAST SEEN**

|  |  |
| --- | --- |
| **DATE ON WHICH THE DECEASED WAS LAST “SEEN” BY A GP OR DOCTOR**  \* this must be a face-to face consultation (i.e. telephone consultations are not sufficient, neither are appointments for vaccinations) |  |
| **NAME OF THE DOCTOR WHO CARRIED OUT THE CONSUTLATION ABOVE** |  |
| **IS THE ABOVE NAMED DOCTOR THE ONE PROPOSING TO ISSUE THE MCCD?**  \* if not, why not? |  |
| **DATE LAST SEEN BY REPORTING DR** |  |

**NEXT OF KIN**

|  |  |
| --- | --- |
| **NAME** |  |
| **ADDRESS** |  |
| **TEL. NUMBER** |  |
| **RELATIONSHIP TO DECEASED** |  |
| **HAS NOK BEEN INFORMED?** |  |

**GP DETAILS**

|  |  |
| --- | --- |
| **NAME** |  |
| **SURGERY ADDRESS** |  |
| **TEL. NO** |  |
| **EMAIL** |  |

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| **SIGNED** |  |
| **DATED** |  |