PART ONE – Eligibility

This form must be completed by an eligible doctor as described overleaf in section 37 of the *Births, Deaths and Marriages Registration Act 1996*, under 'Statutory Requirements'.

1. Is this death a reportable or reviewable death in accordance with the *Coroners Act 2008*?
Note. For information on a reportable or reviewable death, please refer to the Victorian Coroners Court website at coronerscourt.vic.gov.au

☐ **Yes** - Do not complete this form. You must report this death to a coroner or an officer in charge of a police station immediately.

☐ **No**

2. Did you examine the deceased's body after death?

☐ **Yes** - Please specify date of examination ☐ **No**

/ /

3. Were you responsible for providing medical care to the deceased immediately before death?

☐ **Yes** - Please specify date last seen alive by you ☐ **No**

/ /

Do not complete this form if you answered 'No' to Q.2 and Q.3. Give this form to the doctor who either examined the deceased's body after death or who was responsible for providing medical care to the deceased immediately before death.
Go to Question 4 if you answered 'Yes' to **either** Q.2 or Q.3.
Go to Question 5 if you answered 'Yes' to **both** Q.2 or Q.3.

4. Please advise how you can accurately state the cause of this death
Note. Select as many as appropriate.

☐ I am the treating doctor acting on advice from another doctor who examined the deceased's body.

☐ I have referenced the cause of death with the deceased's complete medical history.

☐ I have detailed knowledge of the circumstances surrounding this death.

☐ Other - Please specify

PART TWO – Deceased details

5. Family name

6. Given name

7. Other given name(s)

8. Family name at birth (if known)

9. Date of death / /

10. Age at death Years Months

11. Date of birth / /

12. Sex of deceased ☐ Male ☐ Female ☐ Non Specific

13. How did you confirm the name of the deceased?

☐ Personal knowledge ☐ Medical records ☐ Other - Please specify details

Family name

Given name

Other given name(s)

14. Where did the death occur?

☐ Hospital ☐ Nursing home ☐ Place of residence

☐ Other - Please specify other location (e.g. roadside)

15. Place of death

a) Name of place/institution (if applicable)

b) Street no. and name

c) Suburb/ Town

d) State

e) Postcode

f) Country

16. Was the deceased Aboriginal or Torres Strait Islander?

☐ Aboriginal ☐ Torres Strait Islander

☐ Neither ☐ Both

17. Was a post mortem examination held?

☐ **Yes** ☐ **No** ☐ **Yet to be held**

PART THREE – Causes of death

		Description of disease or condition	Duration between onset & death
18.1 Disease or condition directly leading to death **Note.** Please specify the disease, injury or condition which led directly to the death, not only the mode of dying such as heart or respiratory failure.	a)		Days Months Years
			Days Months Years
			Days Months Years
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)		Days Months Years
	c)		Days Months Years
	d)		Days Months Years
18.2 Other significant conditions **Note.** Provide details of any other significant condition(s) contributing to the death but not related to the disease, injury or condition causing it	e)		Days Months Years
			Days Months Years

PART FOUR – Manner of death

19. Do you reasonably believe or know that the deceased was the subject of a voluntary assisted dying permit

☐ **Yes** - If yes, you MUST complete statements 19(a) and 19(b), and after submission of this form to BDM, notify the Coroner's Court of Victoria.

☐ **No**

19(a). The disease, illness or medical condition that was the grounds for the person to access voluntary assisted dying was

☐ **unknown**

19(b). I reasonably believe or know that the deceased was the subject of a:

☐ voluntary assisted dying permit and the voluntary assisted dying substance specified in the permit was NOT self-administered by the person or administered to the person.

☐ practitioner administration permit and accessed voluntary assisted dying by being administered the voluntary assisted dying substance specified in the permit.

☐ self-administration permit and accessed voluntary assisted dying by self-administering the voluntary assisted dying substance specified in the permit.

PART FIVE – Supporting Information

20. Is there a cardiac pacemaker or other battery-powered device in the body of the deceased?

☐ **Yes** ☐ **No** ☐ **Unknown**

21. Was an operation or invasive procedure performed on the deceased within four weeks of the death?

☐ **Yes** - Please specify type of operation/invasive procedure ☐ **No**

Please specify disease or condition

22. Was the deceased pregnant in the 12 months preceding the death?

YES - Please specify one of the following ☐ **No**

☐ Within six weeks of death

☐ Between six weeks and 12 months of death

☐ **Unknown**

23. Details of the deceased's closest next of kin (if known)

a) Family name

b) Given name

c) Other given name(s)

d) Telephone number

e) Email address

24. Who is arranging the disposal of the deceased's remains?

☐ Funeral director ☐ Next of kin ☐ Other

25. Details of the funeral director or other person disposing of the deceased's remains (if known)

a) Family name

b) Given name

c) Other given name(s)

d) Funeral director's business name (if applicable)

e) Street no. and name

f) Suburb/ Town

g) State

h) Postcode

i) Country

j) Telephone number

k) Email address

Registry Use Only

Reg. details

Officer number

Error code

26. Is the deceased under 18 years of age?

☐ **Yes** - Please specify how many siblings? ☐ **No** ☐

If yes, please specify siblings details

Note. Provide birth details of each sibling in order of birth (from oldest to youngest). Include legally adopted siblings or step brother(s) or sister(s). If there are more than three siblings, attach a separate sheet with the required details.

Sibling 1	**Sibling 2**	**Sibling 3**
Family name	**Family name**	**Family name**
Given name	**Given name**	**Given name**
Other given name(s)	**Other given name(s)**	**Other given name(s)**
Date of birth / /	**Date of birth** / /	**Date of birth** / /
Age	**Age**	**Age**
Life status: ☐ Alive ☐ Deceased ☐ Stillborn	**Life status:** ☐ Alive ☐ Deceased ☐ Stillborn	**Life status:** ☐ Alive ☐ Deceased ☐ Stillborn
Place of birth - Suburb/Town	**Place of birth** - Suburb/Town	**Place of birth** - Suburb/Town
State/Territory	State/Territory	State/Territory
Country	Country	Country
Mother's family name	**Mother's family name**	**Mother's family name**
Mother's given name	**Mother's given name**	**Mother's given name**
Mother's other given name(s)	**Mother's other given name(s)**	**Mother's other given name(s)**
Father or other parent's family name	**Father or other parent's family name**	**Father or other parent's family name**
Father or other parent's given name	**Father or other parent's given name**	**Father or other parent's given name**
Father or other parent's other given name(s)	**Father or other parent's other given name(s)**	**Father or other parent's other given name(s)**

PART SIX – Medical Practitioner's details

27. Family name

28. Given name

29. Other given name(s)

30. Business address

a) Street no. and name

b) Suburb/ Town

c) State

d) Postcode

e) Country

31. Business name

32. Telephone number

33. Email address

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

MED 000

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

☐ **Yes** ☐ **No**

PART SEVEN – Statement

36. I hereby certify that:

a) I am a currently registered medical practitioner;
b) I believe this individual is deceased and the death is neither reportable nor reviewable;
c) I was responsible for providing medical care to the deceased immediately before death; and/or I examined the deceased's body after death; and
d) The particulars and cause(s) of death recorded in this certificate are true to the best of my knowledge and belief.

Medical practitioner's signature

/ /