NURSE VERIFICATION OF EXPECTED DEATH
(for completion by an appropriately trained registered nurse)

Patient's Name:

CHI Number:

Address of Care Setting:

<table>
<thead>
<tr>
<th>Circulation</th>
<th>Respiration</th>
<th>Neurological Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absent carotid pulse for over 1 minute</td>
<td>Absent respiratory effort</td>
<td>Absence of pupillary responses to light</td>
</tr>
<tr>
<td>Absent heart sounds on auscultation for over 1 minute</td>
<td>Absent breath sounds on auscultation for over 1 minute</td>
<td></td>
</tr>
</tbody>
</table>

I have verified the death of .......................................................... in accordance with the NHS Lothian Procedure for Registered Nurse Verification of Expected Death on

Date: .......................................................... Time: .............................................

I anticipate that a Medical Certificate of the Cause of Death will be issued by

Dr. .............................................................................................................. who has been informed of the death directly / by the practice clinical e-mail (please delete as appropriate) on

Date: .......................................................... Time: .............................................

All other relevant tasks (information to relatives, cultural and religious issues, notification of risk of infection, disposal of controlled drugs dispensed to the patient) have been addressed in accordance with NHS Lothian policies and procedures.

Signature of Verifying Nurse: .................................................................

Print Name: ............................................................................................

Date: ........................................................................

This form when completed should be filed in the deceased's medical or district nursing record as appropriate.