FORM C

Dublin Cemeteries Trust Est. 1828

Medical **Certificate**

This form is issued by Dublin Cemeteries Trust, Finglas Road, Dublin 11.Tel: (01) 882 6500. www.dublincemeteriestrust.ie

This Certificate should reach the relevant office
NO LATER THAN 3.00PM ON THE DAY PRIOR TO THE CREMATION.

PURSUANT TO THE BYE LAWS MADE BY GLASNEVIN CREMATORIUM LIMITED

Completion of this form is mandatory. **All questions must be answered** to complete the certificate for the purposes of Cremation.

The doctor completing the certificate must see the body **before and after death**.

Must be **FULLY REGISTERED** on The Medical Register of Ireland i.e. **POST INTERN YEAR**

NOTE: If the death is not due to natural causes and has been referred to the coroner for investigation, this Form C need not be completed.

PART 1: STATEMENT OF TRUTH

PLEASE PRINT IN BLACK PEN ONLY

I certify that I am a registered medical practicioner.

I hereby certify that the answers given below are true and accurate to the best of my knowledge and belief.

Name (Block capitals) _____ Signature _____

Practice Address _____

Date _____ **REGISTERED NUMBER:** _____

Telephone No _____

PART 2: DETAILS OF THE DECEASED

I am informed that application is about to be made for the cremation of the remains of:-

Name of deceased _____

Deceased Address _____

PART 3: REPORT ON THE DECEASED

HAVING SEEN AND IDENTIFIED THE DECEASED BEFORE AND AFTER DEATH.

I give the following answers to the questions set out below:-

1. (a) Were you the regular attending doctor of the Deceased Y ☐ N ☐

   (b) If so, for how long? _____

2. (a) Did you attend the Deceased during his or her last illness Y ☐ N ☐

   (b) If so, for how long? _____

3. (a) When did you last see the deceased alive? Date _____

   (say how many days or hours before death) Days or Hours _____

4. (a) How soon after death did you see the deceased? _____

   (b) What examination did you make? _____

5. On what date and at what hour did he or she die? Date _____ Hour _____

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6 (a) Address where the deceased died _____

(b) Please indicate whether answer to 6 (a) above was: Own residence ☐ Hospital ☐ Nursing Home ☐

Other (please state) _____

7. (a) Are you a relative of the deceased? Y ☐ N ☐

(b) If yes, state relationship _____

8. Have you, so far as you are aware, any pecuniary interest in the death of the deceased? Y ☐ N ☐

9. Cause of death and duration of last illness: (NO ABBREVIATIONS)

Disease or condition directly leading to death (a) _____

due to (or as a consequence of) (b) _____

Approximate interval between onset and death _____

Antecedent causes (c) _____

Morbid conditions, if any, due to (or as a consequence of)

Giving rise to the above

Cause, stating the underlying Condition last (d) _____

Approximate interval between onset and death _____

Other significant conditions contributing to the death

but not related to the disease or condition causing it _____

Approximate interval between onset and death _____

NOTE:IF DEATH IS NOT DUE TO NATURAL CAUSES, THE CORONER SHOULD BE NOTIFIED

10. (a) State how far the answer to the last question Is the result of your own observation _____

(b) If not your own observation, what was the Source of your information? _____

11. (a) Has a Post Mortem been carried out? Y ☐ N ☐

(b) If "YES" state by whom the examination was made _____

12. By whom was the deceased nursed during his or her last illness _____

(Give names and say whether professional nurse, Relatives etc. If the illness was a long one this question Should be answered with reference to The period of four weeks before the death)

_____

13. Who were the persons present (if any) at the moment of death? _____

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14. In view of your knowledge of the deceased's habits and constitution, do you feel any doubt whatsoever as to the character of the disease or the cause of death stated in 9, over?

15. Have you any reason to suspect that the death of the person who has died was violent or unnatural? Y ☐ N ☐

16. Do you have any reason to suspect that the death occurred under or within 24 hours of anaesthetic or medial procedure, or admission to hospital. Y ☐ N ☐

17. Have you any reason whatever to suppose a further examination of the deceased to be desirable? Y ☐ N ☐

18. Has a coroner been informed or has there been any discussion with the coroner about the death? Y ☐ N ☐

Date and time of enquiry _____

If yes, please state coroners office that was contacted

State the outcome of the discussions

19. (a) Did you sign the Death Notification / Registration Form? Y ☐ N ☐

(b) If No, who has? _____

20(a). Has the deceased been fitted with any of the following battery powered and other implants that could cause problems during cremation: **Please indicate either YES Or NO for each device listed (do not leave the box blank).**

a) Pacemaker Y ☐ N ☐
b) Implantable Cardioverter Defibrillators (ICDs) Y ☐ N ☐
c) Cardiac resynchronization therapy devices (CRTDs) Y ☐ N ☐
d) Implantable loop recorders Y ☐ N ☐
e) Ventricular assist devices (VADs): Left ventricular assist devices (LVADs), Right ventricular assist devices (RVADs), or Biventricular assist devices BiVADs) Y ☐ N ☐
f) Implantable drug pumps including intrathecal pumps Y ☐ N ☐
g) Neurostimulators (including for pain & Functional Electrical Stimulation) Bone growth stimulators Y ☐ N ☐
h) Hydrocephalus programmable shunts Y ☐ N ☐
i) Fixion nails Y ☐ N ☐
j) Any other battery powered or pressurised implant Y ☐ N ☐
k) Radioactive implants Y ☐ N ☐
l) Radiopharmaceutical treatment (via injection) Y ☐ N ☐

If the answer to above (a to l) is in the affirmative they must be removed

Please state by whom? _____

20(b). If there are any other prosthesis present (other than a-l above) please state

NOTE: CREMATION MAY BE REFUSED IF CERTAIN PROSTHESIS ARE NOT REMOVED.