This form is issued by Pure Reflections Resomarium, Navan, Co. Meath, Tel: 01-969-6990

FORM C

These Certificates are to be returned to the Funeral Director or Resomarium AS SOON AS POSSIBLE

DEAR DOCTOR, PLEASE READ BELOW VERY CAREFULLY !!!

Before you begin to answer this form, please note that you must fulfill all the criteria below first:

(a) Only a Doctor who attended the patient can complete this form.
It is not permitted for two Doctors to co-complete or co-sign this form.
(b) You must have at least some knowledge of the deceased's medical history.
(c) You must have seen the deceased before death, within 4 weeks of death.
(d) You must have seen the deceased after death.
(e) You must be fully registered on the Medical Register of Ireland i.e. Post-Intern year
(f) You must report the death to your Coroner, if applicable.

If you do not fulfill ALL of the above criteria, then STOP!
You cannot continue. Please contact the Funeral Director immediately

Medical Certificate

Form C

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

Name of Deceased:

Address:

Occupation of Deceased: **Age:**

HAVING SEEN AND IDENTIFIED THE BODY 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?) (a)

(b) If so, for how long?) (b)

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

(b) If so, for how long?) (b)

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 body? And) (a)

(b) What examination did you make?) (b)

5. (a) On what date and at what hour did he or she die?) Date: Hour:

6. (a) What was the place where the Deceased died?) (a)

Give address and

(b) Say whether Deceased's own residence, lodging, hotel,) (b)

hospital, nursing home etc.

7. (a) Are you a relative of the Deceased?) (a)

(b) If yes, state relationship) (b)

8. Have you, so far as you are aware, any financial interest) in the death of the Deceased?

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

		I.	I. Approximate interval between onset and death
Disease or condition directly leading to death	(a)		
		due to (or as a consequence of)	
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)		
		due to (or as a consequence of)	
	(c)		
		II.	II.
Other significant conditions contributing to the death but not related to the disease or condition causing it.			

NOTE: IF DEATH IS DUE TO UNNATURAL CAUSES, (I.E FALL, FRACTURE, ALCOHOL/DRUG RELATED) YOU MUST REPORT THE DEATH TO YOUR CORONER

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) Have you or any other doctor performed an Autopsy on the body?	)	(a)
(b) If "Yes" state by whom the examination was made.	)	(b)
12. By whom was the Deceased nursed during his or her last illness.	)	
(Give names and say whether professional nurse, relative etc. If the illness was a long one this question should be answered with reference to period of four weeks before the death).	)	
13. Who were the persons present (if any) at the moment of death.	)	
14. In view of your knowledge of the Deceased's habits and constitution, do you feel any doubt whatever as to the character of the disease or the cause of death stated in 9. above?	)	

15. Have you any reason to suspect that the Deceased person died either directly or indirectly as a result of:

(a) Violence or misadventure	(a) ☐ Yes ☐ No	
(b) Unfair means	(b) ☐ Yes ☐ No	
(c) Negligence or misconduct	(c) ☐ Yes ☐ No	
(d) Malpractice on the part of others	(d) ☐ Yes ☐ No	
(e) Poison / Alcohol / Drug related (including conditions related to chronic alcohol abuse)	(e) ☐ Yes ☐ No	
(f) Falls / Fractures	(f) ☐ Yes ☐ No	
(g) Occupational related illness including asbestosis or mesothelioma	(g) ☐ Yes ☐ No	
(h) Any other than natural illness or disease for which he/she had been seen and treated by a registered medical practitioner within one month before his/her death:	(h) ☐ Yes ☐ No	

If you have answered yes to any of the above (a) to (h), please discuss with your Coroner who may or may not wish to direct a post mortem examination.

16. Do you know or have you any reason to suspect that the death occurred under or within 24 hours of an anaesthetic or Medical Procedure?

17. (a) Have you any reason to suspect that the death of the Deceased should be reported to the Coroner?) (a)

(b) If so, have you or anybody else done so?) (b)

What was the outcome of the discussion

NB! all nursing home deaths are reportable to your Coroner under the Coroners Act 1962-2019

18. Have you any reason whatever to suppose a further examination of the body to be desirable?)

19. (a) Did you sign the medical Certificate of the Cause of Death?) (a)

(b) If not who has?) (b)

20. Has the Deceased been fitted with?

(a) A Cardiac Pacemaker / Defribulator)	(a) ☐ Yes ☐ No	
(b) A Radioactive Implant)	(b) ☐ Yes ☐ No	
(c) A Fixion Implant)	(c) ☐ Yes ☐ No	
(d) A Bacloflen Pump)	(d) ☐ Yes ☐ No	
(e) Other Prosthesis)	(e) ☐ Yes ☐ No	

NOTE: IMPLANTS AND PACEMAKERS DO NOT NEED TO BE REMOVED PRIOR TO RESOMATION.

YOUR COMPLETION OF THIS FORM C WILL BE DEEMED VOID IF YOU ARE NOT FULLY REGISTERED ON THE MEDICAL REGISTER OF IRELAND I.E. POST INTERN YEAR

Name (please insert name here in block capitals)

Telephone No

(Signature)

Date:

(Address)

Registered Qualification

Year & Month of Full Registration on The Medical Register of Ireland (not provisional)

Medical Registration No