



NOTIFICATION OF EXPECTED DEATH AT HOME

Please contact palliativecare@nshealth.ca if you have any questions.

FAX FORM TO: 902-425-1284

REMINDER TO FAMILIES / CARE PROVIDERS: At the time of death, please call your funeral provider or member of your health care team, do not call 911.

- The person named below is terminally ill, and plans have been made to prepare for a possible death at home.
- The funeral provider of their choosing may remove the body from the home, with the understanding that the Physician / Nurse Practitioner indicated below will either sign the death certificate within 24 hours or make arrangements for another Physician / Nurse Practitioner to sign it.

Client Name (please print):		
Client Address:	Street Address: City: Postal Code:	
Client MSI / Health Card Number:		DOB (YYYY/MON/DD):
Specific Diagnosis:		
Physician / Nurse Practitioner / program that has agreed to sign death certificate:	Name / Program:	Telephone #:
Back up / secondary Physician / Nurse Practitioner who may sign in place of the provider cited above:	Name/Program:	Telephone #:
**Chosen Funeral Provider:	Name:	Telephone #:
The client / delegate / statutory decision maker* has expressed a preference to receive end of life care in the home and consents to the directions provided in this form.	<input type="checkbox"/> Yes	
The client / delegate / statutory decision maker* understands and provides consent to the sharing of this form, by fax or email, to notify local police where applicable, RCMP where no applicable local police service, and funeral provider, in advance of a home death to help facilitate an appropriate response to an expected death at home.	<input type="checkbox"/> Yes → Local Police: _____ <input type="checkbox"/> No → Please note: Sharing this information with local police <i>may</i> avoid police response. Without sharing this information, police may be required to make a home visit and possibly further involvement.	
Signature of health care provider completing this form:		
Name (print):	Signature:	
Position:	Date (YYYY/MON/DD):	
Signature of patient / their delegate / statutory decision maker:		
Name (print):	Signature:	
Date (YYYY/MON/DD):		

*Delegate refers to the patient's chosen decision maker under a Personal Directive and the reference to statutory decision maker refers to a hierarchical list of decision makers provided for in the Nova Scotia Personal Directives Act and who act if a delegate has not been chosen by the patient.

**Given that the patient / statutory decision maker's choice in relation to funeral providers may change this form will not automatically be forwarded to funeral home providers unless the patient / delegate / statutory decision maker would like the information shared.

