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| **REGISTERED NURSE****VERIFCATION OF EXPECTED ADULT DEATH (VEOAD) FORM** |



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| **Details of Deceased** |
| Last name |  | First name(s) |  |
| NHS Number |  | Date of Birth |  |
| Address |  |
| Postcode |  |

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| **General Practitioner Name:** |  |
| Surgery Name & Address: |  |

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| **Details of any person present at time of last observed breath:**  |
| Name (s)  | Relationship to deceased | Contact number(s) |
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| **DNACPR in place, expected death, and no untoward or suspicious circumstances in lead up to death.** | **Yes / No** |
| If ‘**No’**, you are advised **not to undertake VOEAD** and leave any attached devices in place (e.g.: syringe diver, catheter). Record in clinical record action you have taken (e.g. contacted GP, OOH, 101 or 999).  |

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| **Vital signs:** | Tick to confirm  | **Vital signs:** | Tick to confirm |
| Heart sounds absent for at least one minute |  | Central pulse absent for at least one minute |  |
| Pupils unresponsive to light |  | Absence of motor response |  |
| Respirations absent for at least five minutes |  |  |

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| **Date of VOEAD:** |  | **Time of VOEAD** |  |
| **Time of death is the time the death was verified**. **There will be a difference between time of last observed breath and recorded time of death, this could extend into the next day. Explain this to loved ones and support.** |
| If Known; For Cremation or burial. Details of Funeral Director: Information for funeral director (eg: implantable devices, infections): |

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| **RN confirming VOEAD**  |
| **Signature** |  | **Print name** |  |
| Date |  | Time |  |
| Role & base |  | Contact no. |  |

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| **Form to be left with patient for funeral director. Detail to be added to clinical record** |

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| **Rest in Peace** |