Salisbury Crematorium

SALISBURY CITY COUNCIL

Barrington Road
Salisbury
Wiltshire SP1 3JB
Tel: (01722) 333632

Cremation Form 4 (replacing Form B)

THE CREMATION (ENGLAND & WALES) REGULATIONS 2008

Medical Certificate

This form can only be completed by a registered medical practitioner. Please complete this form in full, if a part does not apply enter 'N/A'.

Part 1 – Details of the deceased

Full Name

Address

Occupation or last occupation if retired or not in work at date of death

Where a past occupation of the deceased person may suggest that the death was due to industrial disease you should consider whether to refer the death to a coroner

Part 2 – The report on the deceased

1. What was the date and time of death of the deceased?

   Date

   Time

2. Please give the address where the deceased died.

   Address

   Please state whether it was the residence of the deceased or a hotel, hospital, or nursing home etc.

   ☐ Their home ☐ Hospital Other (please specify)

   ☐ Hotel ☐ Nursing home

3. Are you a relative of the deceased?

   ☐ Yes ☐ No

   If yes, please give the nature of your relationship

4. Have you, so far as you are aware, any pecuniary interest in the death of the deceased?

   ☐ Yes ☐ No

   If 'Yes' please give details

5. Were you the deceased's usual medical practitioner? ☐ N☐

   If 'Yes' please state for how long

Regulation 16 (c)(i) of the Cremation (England and Wales) Regulations 2008

If 'No' please give details of your medical role in relation to the deceased.

6. Please state for how long you attended the deceased during their last illness?

7. Please state the number of days and hours before the deceased's death that you last saw them alive?

Days Hours

8. Please state the date and time that you saw the body of the deceased and the examination that you made of the body

Date Time

Examination

9. From your medical notes, and the observations of yourself and others immediately before and at the time of the deceased's death, please describe the symptoms and other conditions which led to your conclusions about the cause of death.

10. If the deceased died in a hospital at which they were an in-patient, has a hospital post-mortem examination been made or supervised by a registered medical practitioner of at least five years standing who is neither a relative of the deceased nor a relative of yours or a partner or colleague in the same practice or clinical team as you?

☐ Yes ☐ No

If Yes, are the results of that examination known to you ☐ Yes ☐ No

Note: 'Five years' standing' means a medical practitioner who has been a fully registered person within The meaning of the Medical Act 1983 for at least five years and, if paragraph 10 of Schedule 1 to the Medical Act 1983 (Amendment) Order 2002 (S.I 2002/3135) has come into force, has held a Licence to practice for at least five years or since the coming into force of that paragraph.

11. Please give the cause of death

1. (a) Disease or condition directly leading to death (this does not mean the mode of dying such as heart failure, asphyxia, asthenia etc. it means the disease, injury, or complication which caused death.

(b) Other disease or condition, if any, leading to (a)

(c) Other disease or condition, if any, leading to (b)

2. Other significant conditions contributing to the death but not related to the disease or condition causing it.

12. Did the deceased undergo any operation in the year before their death ☐ Yes ☐ No

If Yes, what was the date and nature of the operation and who performed it?

Date of operation ☐☐ ☐☐ ☐☐☐☐ Who performed it

Nature of the operation

13. Do you have any reason to believe that the operation(s) shortened the life of the deceased? ☐ Yes ☐ No

If Yes, please give details

14. Please give the full name and address details of any person who nursed the deceased during the last illness (Say whether a professional nurse, relative etc. If the illness was a long one, this question should be answered with reference to the period of four weeks before the death).

15. Were there any persons present at the moment of death? ☐ Yes ☐ No
If yes, please give the full name and address details of those persons and whether you have spoken to them about the death.

16. If there were persons present at the moment of death, did those persons have any concerns regarding the cause of death ☐ Yes ☐ No
If Yes, please give details

17. In view of your knowledge of the deceased's habit and constitution, do you have any doubts whatever about the character of the disease or condition which led to death? ☐ Yes ☐ No

18. Have you any reason to suspect that the death of the deceased was

Violent: ☐ Yes ☐ No Unnatural: ☐ Yes ☐ No

19. Have you any reason to suppose a further examination of the body is desirable? ☐ Yes ☐ No

If you have answered Yes to questions **17, 18** or **19,** please give details below

20. Has a coroner been informed about the death? ☐ Yes ☐ No
If Yes, please state the outcome

21. Has there been any discussion with a coroner's office about the death of the deceased?

☐ Yes ☐ No

If Yes, please state the coroner's office that was contacted and the outcome of the discussions.

22. Have you given the certificate required for registration of death? ☐ Yes ☐ No
If No, please give the full name and contact details of the medical practitioner who has
Full Name

Address

Telephone Number

23. Was any hazardous implant placed in the body (e.g. a pacemaker, radioactive device or "Fixion" intramedullery nailing system)? ☐ Yes ☐ No

Implants may damage cremation equipment if not removed from the body of the deceased before cremation and some radioactive treatments may endanger the health of crematorium staff.
If yes, has it been removed? ☐ Yes ☐ No

Statement of Truth

I certify that I am a registered medical practitioner.

I certify that the information I have given above is true and accurate to the best of my knowledge and belief and that I know of no reasonable cause to suspect that the deceased died either a violent or unnatural death or a sudden death of which the cause is unknown or in a place or circumstance which requires an inquest in pursuance of any Act.

I am aware that it is an offence to wilfully make a false statement with a view to procuring the cremation of any human remains.

Your full name

Address

Telephone Number

Registered qualifications

GMC Reference Number

Signed

Dated

Once completed, this certificate must be handed or sent in a closed envelope by, or on behalf of, the medical practitioner who signs it to the medical practitioner who is to give the confirmatory medical certificate except in a case where question 10 is answered in the affirmative, in which case the certificate must be so handed or sent to the medical referee at the cremation authority at which the cremation is to take place.

Salisbury Crematorium

Barrington Road
Salisbury
Wiltshire SP1 3JB
Tel: (01722) 333632

Cremation Form 5 (replacing Form C)

THE CREMATION (ENGLAND & WALES)REGULATIONS 2008

Confirmatory Medical Certificate

This form can only be completed by a registered medical practitioner of at least five years' standing who is not either a relative of the deceased, the medical practitioner who issued the medical certificate (Form Cremation 4) or a relative or a partner or colleague in the same practice or clinical team as the medical practitioner who issued that certificate.

'Five years' standing' means a medical practitioner who has been a fully registered person within the meaning of the Medical Act 1983 for at least five years and, if paragraph 10 of Schedule 1 to the Medical Act 1983 (Amendment) Order 2002 (S.I 2002/3135 has come into force, has held a licence to practice for at least five years or since the coming into force of that paragraph.

Please complete this form in full, if a part does not apply enter 'N/A'.

Part 1 – Details of the deceased

Full Name

Address

Occupation or last occupation if retired or not in work at date of death

Part 2 – The report on the deceased

1. Have you questioned the medical practitioner who gave the Medical Certificate (Form Cremation 4)?

☐ Yes ☐ No

If No, please give reasons

In answer to questions 2,3, 4 and 5, please give names and addresses of persons questioned and say whether you spoke to them in person or by telephone. Any failure to answer one of these questions in the affirmative may be treated as an inadequate enquiry.

2. Have you questioned any other medical practitioner who attended the deceased?

☐ Yes ☐ No

If Yes, please give the full name and address details of the medical practitioner(s)

3. Have you questioned any person who nursed the deceased during their last illness, or who was present at the death

☐ Yes ☐ No

If Yes, please give the full name and address details

4. Have you questioned any of the relatives of the deceased? ☐ Yes ☐ No

If yes, please give the full name and address details

5. Have you questioned any other person? ☐ Yes ☐ No

If yes, please give the full name and address details

6. Please state the date and time that you saw the body of the deceased and the examination that you made of the body

Date ☐☐ ☐☐ ☐☐☐☐ Time

Examination

7. Do you agree with the cause of death given in question 11 of Part 2 of the Medical Certificate (Form Cremation 4)? ☐ Yes ☐ No

Reason(s) for disagreeing

1. (a) Disease or condition directly leading to death (this does not mean the mode of dying such as heart failure, asphyxia, asthenia etc. it means the disease, injury, or complication which caused death.

(b) Other disease or condition, if any, leading to (a)

(c) Other disease or condition, if any leading to (b)

2. Other significant conditions contributing to the death but not related to the disease or condition causing it.

Statement of Truth

I certify that I am a registered medical practitioner of at least five years' standing and I am not a relative of the deceased, or a relative or a partner or colleague in the same practice or clinical team as the medical practitioner who has given the Medical Certificate (form Cremation 4).

I certify that the information I have given above is true and accurate to the best of my knowledge and belief and that I know of no reasonable cause to suspect that the deceased died either a violent or unnatural death or a sudden death of which the cause is unknown or in a place or circumstance which requires an inquest in pursuance of any Act.

I am aware that it is an offence to wilfully make a false statement with a view to procuring the cremation of any human remains.

Your full name

Address

Telephone Number

Registered qualifications

GMC Reference Number

Signed

Dated

Once completed, this certificate and the Medical Certificate (Cremation Form 4) must be handed or sent in a closed envelope by one of the Medical Practitioners giving the certificates to the Medical Referee at the Cremation Authority at which the cremation is to take place.

Salisbury
Crematorium

Barrington Road
Salisbury
Wiltshire SP1 3JB
Tel: (01722) 333632

Cremation Form 10 (replacing Form F)

THE CREMATION (ENGLAND & WALES) REGULATIONS 2008

Authorisation of cremation of deceased person by medical referee

Please complete this form in full, if a part does not apply enter 'N/A'.

Part 1 – Details of the deceased

Full Name

Address

Occupation or last occupation if retired or not in work at date of death

Part 2 – Authorisation by medical referee

An application has been made for the cremation of the remains of the deceased.
I am satisfied that –

(a) the requirements of the Cremation (England and Wales) Regulations 2008 have been complied with;
(b) the inquiry/examination made by the persons who gave the relevant certificates has been adequate; and
(c) the fact and cause of death have been definitely ascertained or, if not ascertained, a coroner has opened an inquest.

Accordingly, I authorise the Registrar of the following crematorium to cremate the remains of the deceased within that crematorium.

Name of crematorium

Salisbury

Print your full name

Cremation authority

Salisbury

Signed

Medical Referee to Salisbury Crematorium

Dated

Regulation 23(1) of the Cremation (England and Wales) Regulations 2008.