Government of Western Australia
Department of Health

CREMATION ACT 1929

Cremation Regulations 1954

Form 7 **(Reg. 12)**

Certificate of Medical Practitioner

Certificate to be completed by doctor who attended deceased prior to death
Add additional pages if more space is required.
Attach copies of all relevant laboratory reports, results, certificates etc.

Deceased	Name:
	Address:
	Date of birth: / / Age:
	Marital status: Male Female Unspecified
	Occupation:
Doctor	Name:
	Address:
	Are you a spouse, de facto partner or relative of the deceased? No Yes. Nature of relationship:
	As far as you are aware, do you have a pecuniary interest in the deceased's estate or any other pecuniary interest in the deceased's death? No Yes. Give details:
	Were you the deceased's usual doctor? No Yes
Recent care of deceased	During the 4 weeks prior to death did the deceased receive medical or nursing care? No Yes. Where was the deceased cared for? Hospital Nursing home Home Other If cared for at home or other place, who provided care? Professional health care providers Relatives, friends, others Give names and relationship to the deceased: _____
	Did you attend the deceased during his or her last illness? No Yes Since what date? / /20__
	Did any other doctor(s) attend the deceased during his or her last illness? No Yes. Give names: _____
Last illness	Brief clinical history of last illness including diagnoses and events leading to death.
Details of death	Date / /20__ Time a.m./p.m.
	Place where the deceased died: Home Address _____ Hospital Address _____ Other Address _____

Details of death (cont'd)	Were you present when the deceased died? Yes No. When did you last see the deceased alive? Date / /20__ Time a.m./p.m.
	Did you examine the deceased's body after death? No Yes. Give details: _____
	Do you have any reason to suppose that a further examination of the deceased's remains may be desirable? No Yes. Give details: _____
Cause of death ***(* If a Medical Certificate of Cause of Death is attached, answers are not required to these questions.)***	Was a post mortem performed? No Yes. Give details of results: _____
	*Did you sign the Medical Certificate of Cause of Death? Yes No. Name of the doctor who signed the certificate: _____
	*Direct cause of death:
	*Antecedent causes of death (if any):
	*Conditions contributing to or accelerating death (if any):
Clinical observations	Do you know, or have reason to suspect, that the deceased's death was directly or indirectly due to any of the following? *(tick or circle if yes)* violence poison privation or neglect medical procedure drowning suffocation burns
	In view of the deceased's lifestyle and health, do you have any doubts about the character of the deceased's illness or cause of death? No Yes. Give details: _____
Safety of cremation	At the time of death was the deceased fitted with a cardiac pacemaker, defibrillator or other battery operated implant or device? Yes No/unknown (If yes, has it been removed? Yes/No)
	Had the deceased received any of the following radioactive treatments? *Palliation for bone metastases:* • Strontium-89 injection during the 12 months prior to death No Yes* • Radium-223 injection during the 2 months prior to death No Yes* • Samarium-153 injection during the 3 weeks prior to death No Yes* • Rhenium-188 injection during the week prior to death No Yes* *Infusion for liver cancer or metastases:* •Yttrium-90 or Rhenium-188 during the 2 weeks prior to death No Yes* *Therapy for thyroid cancer, endocrine tumours, or non-Hodgkin's lymphoma:* •Iodine-131 (injection or oral) during the week prior to death No Yes* *Radioactive implant (permanent), e.g. for prostate cancer* •Iodine-125 seed implant during the 12 months prior to death No Yes* * If yes, or if the deceased has received a radioactive treatment (excluding diagnostic scans) in the last 3 months that is not listed— contact the Radiation Safety Officer/Physicist at the treating institution for provision of required information to the crematorium.
	Are you aware of anything else that could render cremation unsafe? No Yes. Give details: _____
Certification of medical practitioner	**I certify that the information set out above is true and correct and that I have not omitted any relevant information.** Signature Date / /20__