

Notification of Expected Death at Home

Fax Form to: 902-425-1284

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

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:	Postal code:
		City:	
Client MSI/health card number:		DOB:	
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/their delegate/ their statutory decision maker* has expressed a preference to receive end of life care in the home and consents to the directions provided for in this form.		<input type="checkbox"/> Yes	
The client/their delegate/ their 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 applicable, 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 (DD/MM/YYYY):	
Signature of patient/their delegate/statutory decision maker:		Name (print):	
		Signature:	
		Date (DD/MM/YYYY):	

*Delegate refers to the patient's chosen decision maker under a Personal Directive and the reference to "statutory decision-maker refers to 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.