LAST ATTENDING PHYSICIAN FORM

(This Form is to be completed by the Last Attending Physician of the Deceased)

DETAILS OF THE LIFE ASSURED

NAME OF THE LIFE ASSURED: _____ S/O, W/O_____

CNIC # _____DATE OF BIRTH_____

DETAILS OF THE DEATH

DATE OF DEATH _____ TIME OF DEATH _____

CAUSE OF DEATH: NATURAL ☐ ACCIDENTAL ☐ SUICIDE ☐ HOMICIDE ☐ OTHER _____ ___

IMMEDIATE CAUSE OF DEATH: _____ DUE TO _____

COMORBIDS / ASSOCIATED ILLNESS_____

DURATION OF THE COMORBID ILLNESSES_____

WAS THE DECEASED UNDER THE INFLUENCE OF ALCOHOL / DRUGS: NO ☐ YES ☐ DETAILS_____

PLACE OF DEATH: HOME ☐ HOSPITAL ☐ OTHERS _____

IF DEATH IN HOSPITAL MENTION THE NAME OF THE HOSPITAL _____

HOSPITAL ADMISSION / REGISTRATION NO._____ DATE OF ADMISSION _____

SECTION TO BE COMPLETED IF DEATH IS DUE TO SICKNESS / ILLNESS

DATE OF ONSET OF ILLNESS_____ DURATION OF TREATMENT _____

SECTIONS TO BE COMPLETED IN CASE OF ACCIDENTAL DEATH

DATE OF ACCIDENT / INJURY _____ PLACE OF INJURY / ACCIDENT_____

WHEN DID YOU FIRST ATTEND THE DECEASED FOR THIS INJURY_____

CAUSE OF THE INJURY / ACCIDENT_____

DETAILS OF INJURIES SUSTAINED_____

PLEASE CHECK IF THE CAUSE OF DEATH IS RELATED TO ANY OF THE BELOW:

POSION ☐ GASES ☐ FUMES ☐ PHYSICAL DEFECT ☐ MENTAL DEFECT ☐ HEAT / SUN STROKE ☐

WAS THE DECEASED SUFFERING FROM HIV : YES ☐ NO ☐ WAS HE SUFFERING FROM AIDS: NO ☐ YES ☐

DATE WHEN HIV / AIDS TEST WAS CONDUCTED _____PLACE OF TEST_____

HAD A POLICE REPORT CONDUCTED: YES ☐ NO ☐ IF YES, NAME OF POLICE STATION_____

WAS A POST MORTEM HELD: YES ☐ NO ☐

ANY OTHER RELEVANT INFORMATION _____

_____

I declare that I have personally attended the deceased patient & all the foregoing statements are correct and true to the best of my knowledge.

PHYSICIAN'S NAME_____**QUALIFICATIONS**_____

DATE _____**CONTACT NO:** _____ **SEAL & SIGNATURE** _____

POSTAL ADDRESS _____