TABLE DEATH REPORT FORM

(To be completed in triplicate)

PART A: MEDICAL PARTICULARS OF PATIENT

NAME OF PATIENT:.....

DATE OF BIRTH: ..... **AGE:** ..... **SEX:** .....

HOSPITAL:.....

HOSPITAL NUMBER:.....

TIME OF ADMISSION:.....

TIME OF PREOPERATIVE ANAESTHETIC ASSESSMENT:.....

1. History:.....

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Drug or Alcohol Addiction:.....

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Previous Anaesthetics: .....

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Treatment: a) Before Admission: .....

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b) After Admission: .....

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2. Pre-operative Examinations:

General condition of Patient:

Good	Fair	Poor	Serious	Grave

Temperature:.....^{0}C Wt: ..... kg Height:.....cm Septic Foci:.....

ASA Grade.....

Cardiovascular System (CVS) BP:..... Pulse .....

.....

Respiratory System (RS): .....

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Abdomen/ Gastrointestinal System (GIT).....

Genitourinary system (GUS): .....

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Other: .....

FBC: .....

U & E: .....

Diagnosis: .....

Time and nature of last meal:.....

Pre-operative preparation if any prescribed or carried out personally by medical practitioner completing Part B

(e.g. I.V. fluids, electrolytes, oxygen, etc) .....

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PART B

SURGICAL PREOPERATIVE ASSESSMENT

DATE & TIME:.....

ASSESSMENT:.....

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Stomach tube (if used) NGT/OGT

Size ..... Make..... When: .....

Name of Practitioner: .....

Designation: .....

Qualifications: .....

Signed: ..... Date .....

Name of Supervisor(if applicable).....

Designation.....

Qualifications:.....

Signed:..... Date:.....

PARTICULARS OF THE PROCEDURES UNDERTAKEN (e.g. Surgery)

Name of Patient .....

(This excludes the anaesthetic administration)

1. Were all relevant particulars in Part B and any other relevant feature(s) noted before the procedure was undertaken?.....

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2. Nature of Procedure.....

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3. Time commenced ..... Terminated .....

4. Details of condition(s) attesting the course of the procedure (e.g. shock, haemorrhage, unconsciousness including pre-operative treatment if prescribed or carried out by medical practitioner).....

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5. Therapy prescribed during the procedure: e.g. blood transfusion drugs) .....

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6. Account of events leading to patient's death (including resuscitative measures) .....

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7. Probable cause of death .....

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Name of Practitioner: .....

Designation: .....

Qualifications: .....

Signed: ..... Date .....

PART C. – THE ANAESTHETIC MANAGEMENT

Name of Patient .....

TIME OF PREOPERATIVE ASSESSMENT:.....

1. (a) Were all particulars in Part B and any other relevant feature(s) noted before the administration of the anaesthetic? .....

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b) ASA Grade.....

2. Premedication prescribed .....

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Was premedication satisfactory .....

3. Time of induction ..... Duration of anaesthetic .....

4. Induction:

a) Intravenous, General/Regional/Local Anaesthetic including muscle relaxants (give amounts and antidotes and state whether used for induction only or fractionally throughout administration).....

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b) Maintenance: Inhalational anaesthetic agent .....%. Maintenance gases (O2/N2O/Air) Flow FiO_2.....

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c) Rectal Administration.....

d) Regional Anaesthetic: Spinal/Epidural Anaesthesia:.....

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Drugs & amounts.....

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Expiry date of any drugs, if known .....

Method of administration (indicate type of apparatus used and mention any specific technique with special reference to controlled or assisted respiration if muscle relaxants used).....

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Complications .....

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Adverse Drug Reactions:.....

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What was the first alarming sign? .....

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Exact Time of respiratory arrest ..... Cardiac Arrest.....

If cardiac massage performed, state interval from cardiac arrest to cardiac massage .....

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Method of cardiac massage and /or defibrillation .....

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Result (return of spontaneous circulation).....

Resuscitative measures .....

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5. Details of drug used and general condition:

Exact time	Drug	Dosage	Injection site	Result	B.P.	Pulse	Respir.

6. Account of death and events leading thereto .....

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7. Probable cause of death .....

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8. Post Mortem requested: Yes ☐ No ☐

9. Reasons why Post-mortem was not done.....

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Name of Practitioner: .....

Designation: .....

Qualifications: .....

Signed: ..... Date .....

Name of Supervisor (if applicable).....

Designation.....

Qualifications:.....

Signed:..... Date:.....

PART D. – OTHER ACCOUNTS OF THE DEATH

Name of Patient .....

1. .....

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Name of Practitioner: .....

Designation: .....

Qualifications: .....

Signed: ..... Date .....

2. .....

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Name of Practitioner: .....

Designation: .....

Qualifications: .....

Signed: ..... Date .....

Name of Supervisor (if applicable).....

Designation.....

Qualifications:.....

Signed:..... Date:.....

MEDICAL AND DENTAL
PRACTITIONERS COUNCIL
REGISTRAR

15 NOV 2016

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APPROVED

28 JUNE 2016