Planned Death At Home (PDAH) Form

*Complete two copies

SECTION 1
CONSENT & PHYSICIAN CONTACT INFORMATION

I, ____________________________, have discussed and understand my health status and prognosis with my physician, ____________________________.

Patient’s name – Print

Physician name - Print

I request to have comfort (palliative) measures only, including interventions or therapies considered necessary to provide comfort and alleviate pain.

_________________________ has been appointed as the substitute decision-maker in the event the above named patient is incapable of making, or understanding their own health care decisions.

Patient’s signature

Date (DD/MM/YY)

Substitute Decision-Maker signature

Date (DD/MM/YY)

Responsible Physician Name

Tel # (contact to advise of death)

Fax #

Cell # (Telehealth # not acceptable)

(see over for agreed responsibilities – do not place physician contact information above prior to physician agreeing to conditions on reverse)

Alternate Physician/Group

Tel # (contact to advise of death)

Fax #

Cell # (Telehealth # not acceptable)

Nurse who obtained verbal MD agreement

Signature & Date

Agency

Telephone

SECTION 2
DO NOT RESUSCITATE ORDER

☐ DNR-c Form completed and in home

☐ Family aware to call nursing agency at time of death (not 911)

SECTION 3
FUNERAL HOME INFORMATION

Funeral Home

Address

Contact Person – Print

Telephone

Fax #

SECTION 4
DISTRIBUTION OF PLANNED DEATH AT HOME FORM

FAXED to:

☐ Funeral Home

☐ MH LHIN (905 855 8989)

☐ Physician

If completing in hospital or MD office (2 copies): Fax to – MH LHIN, Funeral Home, Physician

Give both (2) copies to patient /SDM to take home and place in patient’s home chart.

If completing in patient’s home (2 copies): Copy 1: Leave in patient’s home

Copy 2: Fax to–MH LHIN, Funeral Home, Physician then return to patient’s chart in home
<table>
<thead>
<tr>
<th>Section 5 Pronouncement Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death Pronounced at home on __________ at __________</td>
</tr>
<tr>
<td>Date – (DD/MM/YY) Time</td>
</tr>
<tr>
<td>by ___________________________</td>
</tr>
<tr>
<td>Nurse’s name (Surname, First) - Print Signature Agency</td>
</tr>
<tr>
<td>Dr. ___________________________ notified at __________</td>
</tr>
<tr>
<td>Doctor’s name (Surname, First) - Print Date – (DD/MM/YY &amp; time)</td>
</tr>
<tr>
<td>Death Certificate to be picked up at __________</td>
</tr>
<tr>
<td>Specify Location</td>
</tr>
<tr>
<td>Name of individual _______________________</td>
</tr>
<tr>
<td>Funeral Home ___________________ contacted on __________</td>
</tr>
<tr>
<td>Date (DD/MM/YY &amp; time)</td>
</tr>
</tbody>
</table>

After death has been pronounced, this form enables funeral home to remove the deceased prior to signing of the Medical Certificate of Death. The Nurse will notify the Attending Physician. The Attending Physician or his alternate will complete the Medical Certificate of Death and have it available for the Funeral Home within 24 hours.

Distribution at Death: □ Copy 1 - Funeral Home □ Copy 2 - Agency Copy & fax to MH LHIN
**Planned Death At Home (PDAH) Form**

*Complete two copies*

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**PLANNED DEATH AT HOME PROGRAM**

The first 4 sections of the Planned Death at Home form **must be completed** to confirm a Planned Death at Home is in place.

**Section 1:**

- Responsible physician must be aware that by participating in the planned death at home program, they are agreeing to the following:
  a) To be available for contact 24/7, or arrange alternate physician coverage in the event of client’s death.
  b) To complete the death certificate and make available to the funeral home within 24 hrs. of death.
  c) To ensure covering/alternate physician, if utilized, is aware of above expectations. Therefore, Telehealth is not an acceptable solution for coverage.

- **Do not** place physician contact information in section 1 prior to physician agreeing to above conditions.

**Section 2:**

- DNR-c must be in place to qualify for Planned Death at Home Program.

**Section 3:**

- Funeral home must be made aware and agree to participation in this program.
- Funeral home is responsible for picking up death certificate from physician unless other arrangements have been made.

**Section 4:**

- When sections 1-4 are completed, fax a copy to funeral home, MH LHIN and physician.
- MH LHIN to fax to other agencies involved in patient’s care.

**Section 5:**

- Nurse to complete this section at time of death.
- Copy 1 to accompany body to funeral home.
- Copy 2 fax to MH LHIN, original for agency records
- Nurse calls MH LHIN and Physician to inform of death.

**Completion of this form in the hospital:**

MH LHIN Hospital Care Coordinator to fax form to the MH LHIN office, Funeral Home (if known) and to participating physician. Two copies are given to the patient/SDM to take home to place in the patients chart.

**Completion of this form in the Physician’s office:**

Physician meets with the client/family/SDM to initiate Advance Care Planning. If patient/SDM has decided he/she does not want any resuscitation and wishes to die at home then DNR-c form must be completed. Nurse will contact physician when they have pronounced. Physician agrees that he/she will sign the death certificate and make available to funeral home within 24 hours after death.

**Important note:** Signing over to Telehealth on off duty hours is a **contraindication** for having a Planned Death at Home form completed. Physician is encouraged to discuss with colleagues if there is an opportunity for working together for the patient/family to allow this natural process to take place.