

Patient Identification Form

Last Offices on Infected Patients
(Please print clearly)

Hospital No		Ward		NHS No	
Patient's Name				<input type="checkbox"/> Male <input type="checkbox"/> Female	
_____		_____		DOB ____/____/____	
(Last name)		(First name)		Age _____	
Patient's Religion _____					
Date of death		____/____/____		Time of death	
				Time ____:____	
Date and time of removal (to mortuary)		____/____/____		Date of admission	
				____/____/____	
		Time ____:____			
Name of Nurse					
Signature of Nurse					
Name of Porter					
Name of Consultant					
Diagnosis					
High Risk / Danger of Infection? (if yes, please specify)			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Details: _____		
I.D. Band still on patient?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Property on patient (if so, give details)			<input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____		

