Form A

Mount Jerome Crematorium

Mount Jerome House, 158 Harold's Cross Road, Dublin D6W HY98
Telephone: 01-497 7956 Fax: 01-496 0994
Email: medref@mountjerome.ie

FUNERAL DIRECTOR'S CONFIRMATORY ORDER FORM

PLEASE TICK WHETHER FORM C ☐ OR FORM D ☐ TO FOLLOW

Funeral Director .....

Address ..... Telephone No. .....

Name of Deceased .....

Late Residence .....

Place of Death (if different from above) .....

Age ..... Sex ..... Religion ..... Date of death .....

Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow/er ☐ Civil Partner (Same Sex) ☐

Cremation to take place: Day ..... Date ..... Time .....

URN CHOICE:

Rigid Box ☐ Antique Metal Urn ☐ Wooden Casket ☐ Scattering Tube (which design?) ☐ Supplied Urn ☐

NB! ASHES OF DECEASED ARE NORMALLY AVAILABLE FOR COLLECTION 3/4 WORKING DAYS AFTER THE CREMATION SERVICE

LIVE STREAMING:
Funeral services in our Victorian and Garden Chapels are automatically live streamed.
Please email this office at info@mountjerome.ie if your family wish to opt out of this service option

MEDICAL DEVICES / IMPLANTS:
Basically, if a medical device / implant has any kind of battery, radiation, pressurisation or silicone in its manufacture, it must be removed. Please find below the current list of such medical devices / implants that must be removed prior to cremation. Otherwise, the cremator could suffer serious damage.

(a) Pacemakers
(b) Defibrillators (ICD'S)
(c) Cardiac Resynchronisation Device (CRTD's)
(d) Implantable Loop Recorders
(e) Ventricular Assist Devices (VAD's) or Biventricular Assist Devices (BVAD's)
(f) Implantable Drug Pumps
(g) Fixion Nails
(h) Radioactive Implants (Brachytherapy)
(i) Therapeutic Patches
(j) Implantable Stimulators (for Pain, Bone Growth& Functional Electrical Stimulation)
(k) Hydrocephalus Programmable Shunts
(l) Silicone Implants
(m) Any other battery powered or pressurised Implant
(n) Other Prosthesis (i.e., artificial limb)

CREMATION MAY BE REFUSED IF ANY OF THE ABOVE DEVICES / IMPLANTS ARE NOT REMOVED

NOTE: No batteries, bottles, alcohol, electronic devices, shoes or glass permitted in the coffin as these will also damage the cremator whilst cremating.

I hereby certify that I have complied with all regulations laid down by Mount Jerome Crematorium

Signature of Funeral Director .....

FORMS TO BE SCANNED AND EMAILED TO MEDREF@MOUNTJEROME.IE AS SOON AS POSSIBLE

This form is issued by Mount Jerome Crematorium, Harolds Cross, Dublin Tel: 01 497 7956 Form B

APPLICATION FOR CREMATION BY EXECUTOR OR NEAREST NEXT OF KIN

ALL QUESTIONS MUST BE ANSWERED
PURSUANT TO THE BYE LAWS MADE BY MOUNT JEROME CREMATORIUM

This application should be made preferably by an executor and witnessed by a third party at bottom of this page. If not, then by the nearest surviving relative (NSR). This application CANNOT be made by a Common Law partner or a friend.

(Name of Applicant)..... Mr./Mrs./Miss/Ms
ie Next of Kin or Executor
(Address) .....
.....
(Occupation or Description) .....
apply to Mount Jerome Crematorium to undertake the cremation of the remains of:-
(Name of Deceased).....
First Name in full
(Address) .....
(Occupation).....
Age ..... Sex ..... Religion ..... Date of death.....

Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow/er ☐ Civil Partner (Same Sex) ☐

at MOUNT JEROME CREMATORIUM. on.....
The answers must be completed by the applicant (Executor or NSR only!).

1. Are you an executor or the nearest surviving relative (NSR) of the deceased?, Please state which. If you are the NSR, please state your relationship to the deceased.....

2. If answer to 1 is "No".
   (a) Your relationship to the deceased. (a) .....
   (b) The reasons why the application is made by you and not an executor or nearest surviving relative. (b) .....

3. Has the nearest surviving relative of the Deceased been informed of the proposed cremation?

4. Do you know or have any reason to suspect that the death of the deceased was due directly or indirectly to

(a) Violence or misadventure	Y ☐	N ☐
(b) Unfair means	Y ☐	N ☐
(c) Negligence	Y ☐	N ☐
(d) Malpractice on the part of others	Y ☐	N ☐
(e) Poison / Alcohol / Drug related	Y ☐	N ☐

5. Has the deceased been fitted with any medical device / implant that has any kind of battery, radiation, pressurisation or silicone in its manufacture? Is Yes, Please state what form below and inform your funeral director as he / she has a list of medical devices / implants that will damage the cremator on Form A of the Cremation Forms.....

NB! No batteries, bottles, alcohol, electronic devices, shoes or glass permitted in the coffin as these items will also damage the cremator whilst cremating. Any residual metals (i.e.coffin nails, body implants) following cremation are recycled. Monies received from this recycling programme are donated annually to Our Lady's Hospice Harold's Cross and Barretstown Castle.

NOTE: CREMATION WILL BE REFUSED IF ANY DAMAGING IMPLANT IS NOT REMOVED

LIVE STREAMING:
Funeral services in our Victorian and Garden Chapels are automatically live streamed. If you wish to OPT OUT of this service option, then please have your funeral director email (info@mountjerome.ie) this instruction to this office.

I declare that to the best of my knowledge and belief the information given in this, is correct and no material in particular has been omitted.

Date: ..... *(Signature of Applicant) i.e. Executor or NSR* .....

The applicant is known to me and I have no reason to doubt the truth of any of the information furnished by the applicant.

Date: ..... *(Signature of Witness)*.....

(Address).....

Please Print Name ..... Date .....

This form when completed should be sent to the Secretary, Mount Jerome Crematorium, 158 Harolds Cross Road, Dublin D6W HY98
Email: medref@mountjerome.ie

This form is issued by Mount Jerome Crematorium, 158 Harolds Cross Road, Dublin D6W HY98 Tel: 01 497 7956
Email: medref@mountjerome.ie

This form is to be returned to the Funeral Director or Crematorium **AS SOON AS POSSIBLE**

DEAR DOCTOR, PLEASE READ BELOW VERY CAREFULLY!!!

Before you begin to answer this form, please note that you must fulfil all the criteria below first:

(a) Only a Doctor who attended the patient can complete this form.
It is not permitted for two Doctors to co-complete or co-sign this form.
(b) You must have at least some knowledge of the deceased's medical history.
(c) You must have seen the deceased before death, within 4 weeks of death.
(d) You must have seen the deceased after death.
(e) You must be fully registered on the Medical Register of Ireland i.e. Post-Intern year
(f) You must report the death to your Coroner, if applicable.

If you do not fulfil ALL of the above criteria, then STOP!
You cannot continue. Please contact the Funeral Director immediately

YOUR COMPLETION OF THIS FORM C WILL BE DEEMED VOID IF YOU ARE NOT FULLY REGISTERED ON THE MEDICAL REGISTER OF IRELAND I.E. POST INTERN YEAR

I hereby certify that the answers given above are true and accurate to the best of my knowledge and belief.

Name ..... (Signature) .....
(please insert name here in block capitals). Date: .....
Telephone No. ..... (Address) .....
Medical Registration No ....
Registered Qualification ..... Year & Month of Full Registration on The Medical Register of Ireland .....
(not provisional)

FORM C

I am informed that application is about to be made for the cremation of the remains of:
(Name of Deceased) .....Date Of Birth..... (Age).....
(Address) .....

HAVING SEEN AND IDENTIFIED THE BODY BEFORE AND AFTER DEATH

I give the following answers to the questions set out below:-

1. (a) Were you the regular attending doctor of the Deceased) (a) .....
   (b) If so, for how long?) (b) .....

2. (a) Did you attend the Deceased during his or her last illness) (a) .....
   (b) If so, for how long?) (b) .....

3. (a) When did you last see the Deceased alive?) (Date) .....
   (say how many days or hours before death)) (Days or Hours) .....

4. (a) How soon after death did you see the body? and) (a) .....
   (b) What examination did you make?) (b) .....
   If you did not see the body after death - you cannot complete this form

5. (a) On what date and at what hour did he or she die?) Date ..... Hour .....

6. (a) What was the place where the Deceased died?) (a) .....
   Give address and .....
   (b) Say whether Deceased's own residence, lodging, hotel
   hospital, nursing home etc.) (b) .....

7. (a) Are you a relative of the Deceased?) (a) .....
   (b) If yes, state relationship) (b) .....

8. Have you, so far as you are aware, any financial interest
   in the death of the Deceased.) .....

9. Cause of death and duration of last illness: **NO ABBREVIATIONS**

			Approximate interval between onset and death
I.		**I.**	
Disease or condition directly leading to death	(a)	.....	.....
		due to (or as a consequence of)	
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)	.....	.....
		due to (or as a consequence of)	
	(c)	.....	.....
II.		**II.**	
Other significant conditions contributing to the death but not related to the disease or condition causing it.		.....	.....

NOTE: IF DEATH IS DUE TO UNNATURAL CAUSES, (IE FALL, FRACTURE, ALCOHOL/DRUG RELATED) YOU MUST REPORT THE DEATH TO YOUR CORONER

10. (a) State how far the answer to the last question is the result of your own observation. .....

(b) If not your own observation, what was the source of your information? .....

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11. (a) Have you or any other doctor performed an Autopsy on the body?) (a) .....

(b) If "Yes" state by whom the examination was made.) (b) .....

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12. By whom was the Deceased nursed during his or her last illness.) .....

(Give names and say whether professional nurse, relative etc. If the illness was a long one this question should be answered with reference to period of four weeks before the death).) .....

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13. Who were the persons present (if any) at the moment of death.) .....

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14. In view of your knowledge of the Deceased's habits and constitution, do you feel any doubt whatever as to the character of the disease or the cause of death stated in 9. above?) .....

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15. Have you any reason to suspect that the Deceased person died either directly or indirectly as a result of:

(a) Violence or misadventure — (a) Yes / No.....

(b) Unfair means — (b) Yes / No.....

(c) Negligence or misconduct — (c) Yes / No.....

(d) Malpractice on the part of others — (d) Yes / No.....

(e) Poison / Alcohol / Drug related (including conditions related to chronic alcohol abuse) — (e) Yes / No.....

(f) Falls / Fractures — (f) Yes / No.....

(g) occupational related illness including asbestosis or mesothelioma — (g) Yes / No.....

(h) Any other than natural illness or disease for which he/she had been seen and treated by a registered medical practitioner within one month before his/her death: — (h) Yes / No.....

If you have answered yes to any of the above (a) to (h), please discuss with your Coroner who may or may not wish to direct a post mortem examination

16. Do you know or have you any reason to suspect that the death occurred under or within 24 hours of an anaesthetic or Medical Procedure .....

17. (a) Have you any reason to suspect that the death of the Deceased should properly be reported to the Coroner?) (a).....

(b) If so have you or anybody else done so) (b).....

What was the outcome of the discussion .....

.....

NB! all nursing home deaths are reportable to your Coroner under the Coroners Act 1962 - 2019

18. Have you any reason whatever to suppose a further examination of the body to be desirable?) .....

19. (a) Did you sign the medical Certificate of the Cause of Death?) (a).....

(b) If not who has?) (b).....

20. (1) Has the Deceased been fitted with?

(a) Pacemakers — 1.(a) Yes / No.....

(b) Defibrillators (ICD'S) — (b) Yes / No.....

(c) Cardiac Resynchronisation Device (CRTD's) — (c) Yes / No.....

(d) Implantable Loop Recorders — (d) Yes / No.....

(e) Ventricular Assist Devices (VAD) or Biventricular Assist Devices (BVAD) — (e) Yes / No.....

(f) Implantable Drug Pumps including Intrathacal Pumps — (f) Yes / No.....

(g) Fixion Nails — (g) Yes / No.....

(h) Radioactive Implants (Brachytherapy) — (h) Yes / No.....

(i) Therapeutic Patches — (i) Yes / No.....

(j) Implantable Stimulators — (J) Yes / No.....

(k) Hydrocephalus Programmable Shunts — (k) Yes / No.....

(l) Silicone Implants — (l) Yes / No.....

(m) Any other battery powered or pressurised Implant — (m) Yes / No.....

(n) Other Prosthesis (i.e., artificial limb) — (n) Yes / No.....

(2) If any answer to any of the above is in the affirmative, has the device / implant been removed? — 2.Yes / No.....

CREMATION MAY BE REFUSED IF ANY OF THE ABOVE DEVICES / IMPLANTS ARE NOT REMOVED

Mount Jerome Crematorium

Form D

CORONER'S CERTIFICATE FOR CREMATION

I Certify that:-

I am satisfied that there are no circumstances likely to call for further examination of the body.

PARTICULARS OF DECEASED PERSON

Full Names .....

Sex .....

Age .....

Date of Death .....

Place of Death .....

(Please insert name here in block capitals).....

Signature .....

Coroner for the of

Date .....

IF THE DECEASED HAS ANY OF THE BELOW LISTED MEDICAL DEVICES / IMPLANTS FITTED, THEY MUST BE REMOVEDAS THEY CAN CAUSE SERIOUS DAMAGE TO A CREMATOR.

(a) Pacemakers

(b) Defibrillators (ICD'S)

(c) Cardiac Resynchronisation Device (CRTD's)

(d) Implantable Loop Recorders

(e) Ventricular Assist Devices (VAD's) or Biventricular Assist Devices (BVAD's)

(f) Implantable Drug Pump

(g) Fixion Nails

(h) Radioactive Implants (Brachytherapy)

(i) Therapeutic Patches

(j) Implantable Stimulators (for Pain, Bone Growth& Functional Electrical Stimulation)

(k) Hydrocephalus Programmable Shunts

(l) Silicone Implants

(m) Any other battery powered or pressurised Implant

(n) Other Prosthesis (i.e., artificial limb)

NOTE: This Certificate is issued for the purpose of cremation only and must be delivered to the Funeral Director or Mount Jerome Crematorium as soon as possible. The Cremation cannot be proceeded with unless this Certificate is so delivered.

Mount Jerome Crematorium Contact Details:
Telephone: 01-497 7956 Email:medref@mountjerome.ie