NSW GOVERNMENT Health

Facility:

REPORT OF DEATH ASSOCIATED WITH ANAESTHESIA/SEDATION
(PREVIOUSLY FORM B)

SMR010511

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

LOCATION OF DEATH (eg, OR, ICU, HDU etc)	DATE OF DEATH	TIME OF DEATH	WEIGHT

Pre-operative diagnosis / condition

ASA classification *(please tick)* ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ E

Operation(s) / procedure(s)

Findings at operation/procedure

Induction	DATE OF INDUCTION	TIME OF INDUCTION	TIME ANAESTHETIC CEASED
Anaesthetic / Sedation *(tick all relevant boxes)*	☐ GA ☐ Regional ☐ Local ☐ Sedation		
List of all drugs given & doses *(including premedication if any)*			

Brief description of events

Likely cause(s) of death

Anaesthetist / Sedationist *(Please print name, title and qualifications)*
1.
2.

Contact details of Medical Officer completing this report *(for feedback)*	PRIVATE MAILING ADDRESS	HOSPITAL ADDRESS

Name of Medical Officer completing this report:	SIGNATURE	DATE

Please send completed form to:
Secretary NSW Health, c/o Special Committee Investigating Deaths Under Anaesthesia
Clinical Excellence Commission, Locked Bag 8 HAYMARKET NSW 1240

SPECIAL COMMITTEE INVESTIGATING DEATHS UNDER ANAESTHESIA

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

NH601685 301014

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301014 NH601685

Hospital Copy