



**JOINT PROTOCOL FOR
EXPECTED / PLANNED HOME DEATHS
IN
BRITISH COLUMBIA**

December 2006

JOINT PROTOCOL FOR EXPECTED/PLANNED HOME DEATHS IN BRITISH COLUMBIA

This document is intended for health care professionals and agencies involved in expected/planned home deaths.

INTRODUCTION

The *Joint Protocol for Expected/Planned Home Deaths in British Columbia* (2006) replaces the *Joint Protocol for the Management of Planned Home Deaths* (1996). The original document was released by the Ministry of Health, BC Ambulance Services, the Office of the Chief Coroner, and the BC Medical Association in collaboration with: the BC College of Physicians and Surgeons, BC Hospice Palliative Care Association, (former) Registered Nurses Association of BC, Funeral Service Association of BC, RCMP "E" Division, (former) BC Association for Community Care, BC Municipal Police Chiefs Association, and the (former) BC Health Association.

The 2006 edition is the result of the efforts of the Fraser Health Authority who took the lead in determining the need for revisions and worked in concert with health authorities, the Ministry of Health, and other stakeholders to clarify the procedures associated with expected/planned home deaths.

The primary changes to this document are the clarification that in BC there is no legal obligation to pronounce death. However, in the absence of a pronouncement of death, funeral directors require assurance that the death was expected and planned before they will remove the body; thus, the Protocol includes a mechanism for providing this assurance through a form completed by the physician and family entitled *Notification of Expected Death* which is forwarded to the funeral home in advance of death. The Joint Protocol has also been updated to refer to the provincial No Cardiopulmonary Resuscitation (CPR) form rather than a Do Not Resuscitate (DNR) form reflecting current, more precise nomenclature and the revised Ministry of Health form HLTH302.1 Rev 2003/05/01.

PURPOSE OF JOINT PROTOCOL

- Clarify the process and procedures involved in managing anticipated natural home deaths in the context of a terminal illness;
- Delineate the roles and responsibilities of health professionals and agencies involved in a home death.

DEFINITIONS

Death at home may fall under several categories:

- A **natural expected death** where deterioration to death occurs in its natural sequence but plans may not be in place.
- A **planned, expected home death** where an individual has chosen to die at home with the support of family and plans have been clearly made and documented beforehand.
- An **unexpected or suspicious death** which **MUST** be reported to the Coroner (see Appendix A).

Family refers to those closest in knowledge, care and affection to the person. Specifically, it includes family of origin (birth parents and siblings); family of acquisition (relations by marriage or contract); and family of choice: anyone the person chooses to have closest to them.

STATEMENT OF PRINCIPLES

- Individuals have the right to choose to die at home and to expect to receive support and coordinated care at home.
- Individuals have the right to have their wishes respected.
- When a patient has indicated resuscitation is not wanted or the physician has indicated that resuscitation would be medically futile, resuscitation attempts are not initiated.
- Direction for no resuscitation is documented by the physician signature on the Ministry of Health *No Cardiopulmonary Resuscitation* form (HLTH 302.1 Rev 2003/05/01).
- A clear plan must be in place so families know what action to take at the time of death.
- Providing good care at end of life requires attention to details of care. When an individual has chosen to die at home, changes are expected and there is the potential for development of crises. Therefore, ensuring access to support of community care providers, appropriate medical support, and medications is essential.
- Referral to community home care nursing services and/or hospice palliative services are best made early. This allows for good care planning and for relationships to be established.
- Effective care requires that all providers and involved agencies understand their role in natural expected death.
- Patients and their families have an ongoing right to change their minds and revise any plans they have made.

PLANNING FOR DEATH AT HOME

Expected home deaths are anticipated natural events and with appropriate planning:

- Patients and families can receive appropriate supports
- The coroner does not need to be notified of an expected death from natural causes, unless there are concerns regarding the cause of death;
- Police do not need to be called when a death was expected;
- Ambulance services and/or 911 should not be contacted when the death was expected;
- The funeral home is aware and appropriate authorization is in place so they can be contacted directly once death has occurred as per protocol.

NOTE: There are communities in British Columbia without physicians residing in the community and without a funeral home. It is especially important that these situations be discussed by the individual, family, and physician and an appropriate plan suitable for the community be made in advance. Families who live in these communities should also clearly identify their location and thus their need for an ambulance for transportation of the body when they contact the ambulance call centre.

Each death is unique. It can be a time of crisis or relative calm. Coordination of care is essential to support all individuals participating in this event. Preparation for a death which is expected to occur in the home involves these key elements:

Care Planning

Discussion about a planned home death should occur in the context of a life-threatening/terminal illness where death is anticipated. This should be a collaborative process involving the patient/family, family physician, nursing personnel and others as needed giving primary consideration to what is in the best interest of the patient and family.

Planning for care at end of life requires open discussion with the patient, family and care providers about what to expect and what options exist to prepare for predictable clinical challenges. A clear plan is negotiated and documented.

Resuscitative Interventions

- The *No Cardiopulmonary Resuscitation* form (HLTH 302.1 Rev 2003/05/01) is used as the communication tool to document an individual's wishes/physician orders regarding resuscitative interventions¹.
- The provincial *No Cardiopulmonary Resuscitation* form is completed and signed by the physician and patient/authorized substitute decision maker where possible.
- Original of the *No Cardiopulmonary Resuscitation* form is kept in the home, preferably on the fridge, but should be carried with the individual if away from home

¹ Health authorities may use other forms for a physician's NO CPR Order; for example, VIHA uses an advance directive for patients' instructions for future health care that includes a physician's NO CPR Order. If a health authority uses a form other than or in addition to the HLTH 302.1 Rev 2003/05/01, the health authority is responsible for communicating this to regional BCAS staff, physicians, and other appropriate professionals.

for any reason unless the patient is wearing a medical alert® NO CPR bracelet which is an extension of the NO CPR form.

- The physician retains a copy of the *No Cardiopulmonary Resuscitation* form.
- Community Home Care Nursing Services receives a copy of the *No Cardiopulmonary Resuscitation* form and notifies the home support agency, if involved, that a 'No Cardiopulmonary Resuscitation' order is in place.
- Clear instructions re "What to do at time of death" and "Who to call" are reviewed with the family and documented at the back of the 'No Cardiopulmonary Resuscitation' form, noting special phone numbers.
- If a patient and family are not willing to sign a 'No Cardiopulmonary Resuscitation' form when the physician determines the resuscitative interventions are futile, the physician should discuss that calling 911 at the time of death without a signed 'No Cardiopulmonary Resuscitation' form initiates a response from the BC Ambulance Services to attempt resuscitation as well as an automatic police and coroner investigation of the death. The physician may still complete the form and indicate that the discussion has occurred but that the patient (and or ASDM) has declined signing the form.

Pronouncement of Death

- Pronouncement is often done to provide assurance and support to family and to verify that this was an expected natural death.
- While there is no legal requirement that death be pronounced, it is widely recognized that it is sound clinical and ethical practice for nurses and physicians to be available to pronounce death.
- Health care professionals who may pronounce death include physicians, registered nurses, registered psychiatric nurses and licensed practical nurses.
- Families may decline to have a physician or nurse come to the home to pronounce death.
- Families who have declined pronouncement can change their mind at the time of death and decide to wait until a physician or nurse can pronounce death at home.
- If there are concerns or potential for questions or concerns regarding the manner of death, the physician should plan to pronounce death.

Plan For Time Of Death

The family must contact a funeral home of their choice to make necessary advance arrangements. In the case of expected, planned home death, where the physician has no concerns or questions, and where a *No Cardiopulmonary Resuscitation* form has been completed, the physician may discuss with the family the option of declining to have a physician or nurse come to the home to pronounce at the time of death.

In these cases where pronouncement is declined, a *Notification of Expected Death* form MUST be completed by the physician

A *Notification of Expected Death* form verifies that:

- The death is a natural expected one
- The death is expected within the next days or few weeks

- The family has declined pronouncement and has agreed at the time of death to wait for at least 1 hour after breathing has stopped to then call the funeral home directly to remove the body
- The physician agrees to be available to sign (or ensures that his/her designate is available) the *Physician's Medical Certification of Death* within 48 hours of the time of death
- The person with the right to control disposition of the deceased has provided authorization to the funeral home to transfer the body from the home to the funeral home consistent with Section 8 of the *Cremation, Interment and Funeral Services Act*.
- Once the physician signs the *Notification of Expected Death* form with the family, the physician forwards a copy to the Funeral Home of choice, and the Community Nursing Service Office where the patient receives home care nursing services.
- The Funeral Home ensures that the person authorized to control the disposition of the deceased has also signed the *Notification of Expected Death* form.

Care At the Time of Death

The plan for the time of death must include instructions to the family NOT to call 911. BC Ambulance Services paramedics cannot pronounce and the families should be instructed not to call them. The plan for time of death should also include who can be called for emotional support.

If pronouncement is planned, the family will follow the plan for time of death:

- Call the physician or nurse to inform them of the death and ask them to pronounce as agreed.

If a *Notification Of Expected Death* form is completed, the family will follow the plan for time of death:

- Note the time of death, waiting at least 1 hour after breathing has stopped, and then call the funeral home to have the body transferred to the funeral home.

If the family changes its mind at the time of death and wishes to have pronouncement:

- Call the physician or nurse to inform them of the death and wait until someone can come to the home to pronounce death, recognizing that this may be a number of hours.

Transportation of the Deceased

- Individuals and /or family are encouraged to make prior arrangements with a funeral home.
- The funeral home is legally required to obtain verbal or written authorization from the person with the right to control disposition under Section 5 of the *Cremation, Interment and Funeral Services Act* prior to removing the body. The funeral home completes this documentation on the *Notification of Expected Death* form.
- Funeral homes can move the body directly from the home to the funeral home with the authorization of the person with the right to control disposition once the physician or nurse has pronounced the death OR at least one hour after breathing has stopped when a *Notification of Expected Death* form is in place.

- There is no urgency to transfer the body for a number of hours. BC Funeral Association recommends, however, that the family not wait longer than 4 to 6 hours after death has occurred.

Certification of Death

- Certification of the cause of death is the legal responsibility of physicians.
- Medical certification of death by a physician is necessary within 48 hours of death and before the body can be released for burial or cremation.
- The funeral home can contact the physician to obtain the Physician's *Medical Certification of Death* form.

ROLES OF PROVIDERS

Role of Physician

The physician has a central role and an obligation to ensure that there is an appropriate plan in place for all patients in the context of a life-threatening/terminal illness where death is anticipated.

Prior to the death:

- Discuss options for care with the patient and family and/or significant others including the patient's option to die at home. Provide opportunity for the patient to express wishes about their care and resuscitative interventions.
- Supervise the patient's care, which may include home visits.
- Make an early referral to the Community Home Care Nursing Service and/or an appropriate hospice palliative care service.
- Complete a referral to the BC Palliative Care Benefits program as appropriate
- Discuss futility of resuscitation with patient and family and sign the No CPR form and obtain signatures from patient and next of kin as appropriate.
- Give copies of the signed No CPR form to the family and Community Nursing Services and inform them if patient has a NO CPR bracelet already.

With approaching death:

- Provide explanation to family about the anticipated changes of impending death.
- Ensure care plans are in place for predictable challenges at end of life including appropriate medications and supplies in discussion with the community health nurse.
- Discuss arrangements for actions at the time of death with patient, family, and with the Community Nursing Services.
- If there are concerns regarding the manner of the anticipated death, the physician is responsible to plan to be available to pronounce death and to involve the Coroner's office as appropriate (Section 9 of the *Coroner's Act*).
- Identify family situations where the option of waiving the need for pronouncement and completion of the *Notification of Expected Death* may be appropriate and discuss that option with the family.
- If pronouncement is planned, gives the family clear instructions on:
 - What to do at the time of death.
 - Who will be pronouncing death, and how they can be reached.
 - How the physician or nurse can be reached at the time of death.

- How the back-up physician can be reached should the physician be unavailable or cannot be reached at the time of death.
- If no one is available to pronounce during the night, discuss the need to wait until the morning to contact the nurse or physician.
- If attendance to pronounce is **NOT** needed:
 - Complete a *Notification of Expected Death* form with the family and provide a copy to the funeral home to verify that this is a natural expected death; that the family has declined pronouncement and that the body can be moved from the home without attendance of a physician or nurse to pronounce death.
 - Give the family clear instructions for what to do at the time of death.
 - Instruct the family after the death to wait at least 1 hour after breathing has stopped to call the funeral home to have the body moved.
 - Arrange after-hours support with on-call physician/nursing services for times when he/she is unavailable and advise on-call physician/nursing services of any arrangements which have been made.

At time of death

- If the plan is for pronouncement, attend the home to pronounce death; or receive notification of pronouncement from the community home care nurse.
- If a *Notification of Expected Death* form is completed, receive notification of the death from the family or care provider.
- If there are concerns or potential for questions or concerns regarding the manner of death, call the Coroner's office.
- Complete the *Physician's Medical Certification of Death*.

Role of Community Home Care Nursing

- Participate in discussions with the individual, family and physician regarding the plan of care.
- Communicate the plan of care to the home support agency, if involved.
- Review the signs of impending death with family.
- Ensure the family understands instructions for what to do at the time of death.
- Assists the family to plan for who they can call for emotional support at the time of death if wished.
- Confirm with the physician, arrangements for time of death: Either pronouncement or that a *Notification of Expected Death* form is completed.
- If pronouncement is planned, confirm with the physician, who will pronounce death and how family are to contact physician or nurse.
- If it is the nurse who will pronounce death, give the family clear instructions on how to contact the nurse when death occurs.
- Pronounce death when in the home when the individual dies or when called by the family as pre-arranged.
- Develop a procedure with the home support agency to clarify responsibilities of the agency and the home support worker if he/she is alone with the patient at the time of death.

Role of Home Support Agency

- Work with Community Home Care Nursing Services to ensure understanding of the plan of care.
- Develop a procedure with Community Home Care Nursing Services to clarify responsibilities of the agency and the home support worker if he/she is alone with the individual at the time of death.
- When a *Notification of Expected Death* form has been completed and a home support worker is alone in the home at the time of that person's death, it is the responsibility of the family or designate who signed the 'notification form' to ensure a family member or designate returns to the home and then calls the funeral home after at least one hour to authorize transfer of the body from the home. Calling the funeral home after death is not a responsibility of the home support worker.
- Normally, the home support worker should stay in the home with the deceased until (a) a family member arrives to take charge or (b) the body is removed from the home after death is pronounced.

Role of Funeral Home/Funeral Directors

- Welcome and encourage inquiries and personal interviews on the part of anyone desiring factual information on procedures or funeral costs.
- If requested, share information with families about private transfer of the body after death in accordance with the Cremation, Interment and Funeral Services Regulation, Section 4 and 5.
- Work with the individual and/or family to ensure proper authorization and to make arrangements for transportation of the deceased, discuss appropriate bereavement rites and ceremonies, and options available for final disposition.
- Ensure systems are in place for *Notification of Expected Death* forms to be stored.
- Respond to the call from a member of the family, physician, registered nurse, or clergyman who notifies the funeral home that a death has occurred.
- Confirm that the appropriate authorization is provided from the person with the right to control disposition of the deceased consistent with Sections 5 and 8 of the *Cremation, Interment and Funeral Services Act*
- Pick up the body of the deceased from the home after death has been pronounced or in accordance with the *Notification of Expected Death* form at least one hour after death has occurred, and the legally authorized representative requests it.
- Notify police or coroner if there are any concerns about the manner of death.
- Obtain a copy of the Physician's *Medical Certification of Death* from the physician, within 48 hours after death has occurred.
- Complete the Registration of Death form.

REFERENCES

British Columbia Ambulance Service (BCAS) Field Operations Policy and Procedure Manual 6.4.13.1.2 "No CPR" Orders March 22nd, 2001 and 6.4.13.2 Deceased Persons at Scene 2001.

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College of Registered Nurses of British Columbia . (2003). *Practice Standard For Registered Nurses And Nurse Practitioners: Pronouncement of Death* (November, Pub. No. 342). Vancouver, British Columbia:

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In consultation with: Office of the Chief Coroner; BC Ambulance Services; BC College of Physician & Surgeons; College of Registered Nurses of BC; BC Medical Association; BC Hospice Palliative Care Association; Funeral Services Association of BC; RCMP 'E' Division; Business Practices and Consumer Protection Authority; Interior Health Authority; Vancouver Island Health Authority; Northern Health Authority; Provincial Health Services Authority

APPENDIX A: CORONER'S ACT, SECTION 9

9 (1) A person must immediately notify a coroner or a peace officer of the facts and circumstances relating to a death if he or she has reason to believe that a person has died

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- (a) as a result of violence, misadventure, negligence, misconduct, malpractice or suicide,
 - (b) by unfair means,
 - (c) during pregnancy or following pregnancy in circumstances that might reasonably be attributable to pregnancy,
 - (d) suddenly and unexpectedly,
 - (e) from disease, sickness or unknown cause, for which the person was not treated by a medical practitioner,
 - (f) from any cause, other than disease, under circumstances that may require investigation, or
 - (g) in a correctional centre, youth custody centre or penitentiary or a police prison lockup.
- (2) The person in charge of an institution must immediately give notice to the coroner of the death of a person who dies
- (a) while a resident of or an in-patient in
 - (i) [Repealed 1999-39-6.]
 - (ii) a place for the examination, diagnosis, treatment or rehabilitation of mentally disordered persons to which the *Mental Health Act* applies, or
 - (iii) a public or private hospital to which the person was transferred from a place referred to in subparagraph (ii), or
 - (b) while the person is, whether or not on the premises or in actual custody,
 - (i) a patient of a place referred to in paragraph (a) (ii), or
 - (ii) committed to a correctional centre, youth custody centre or penitentiary or a police prison or lockup.
- (3) If a person dies while detained by or in the actual custody of a peace officer, the peace officer must immediately notify the coroner.
- (4) A peace officer who is notified under subsection (1) must notify a coroner.

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**APPENDIX B: CREMATION, INTERMENT AND FUNERAL SERVICES ACT,
Sections 5 and 8**

Control of disposition of human remains or cremated remains

5 (1) Subject to this section and section 8 (3) (b) (i) [*requirement for authorization before funeral services or disposition*], the right of a person to control the disposition of the human remains or cremated remains vests in, and devolves on, the following persons in order of priority:

- (a) the personal representative named in the will of the deceased;
- (b) the spouse of the deceased;
- (c) an adult of child of the deceased;
- (d) an adult grandchild of the deceased;
- (e) if the deceased was a minor, a person who was a legal guardian of the person of the deceased at the date of death;
- (f) a parent of the deceased
- (g) an adult sibling of the deceased;
- (h) an adult nephew or niece of the deceased;
- (i) an adult next of kin of the deceased, determined on the basis provided by sections 89 and 90 of the *Estate Administration Act*;
- (j) the minister under the Employment and Assistance Act or, if the official administrator under the Estate Administration Act is administering the estate of the deceased under that Act, the official administrator;
- (k) an adult person having a personal or kinship relationship with the deceased, other than those referred to in paragraphs (b) to (d) and (f) to (i).

(2) If the person at the top of the order of priority set out in subsection (1) is unavailable or unwilling to give instructions, the right to give instructions passes to the person who is next in priority.

(3) If, under subsection (1), the right to control disposition of human remains or cremated remains passes to persons of equal rank, the order of priority

- (a) is determined in accordance with an agreement between or among them, or

- (b) in the absence of an agreement referred to in paragraph (a), begins with the eldest of the persons and descends in order of age.
- (4) A person claiming that he or she should be given the sole right to control the disposition of the human remains or cremated remains may apply to the Supreme Court for an order regarding that right.
- (5) When hearing an application under subsection (4), the Supreme Court must have regard to the rights of all persons having an interest and, without limitation, give consideration to:
- (a) the feelings of those related to, or associated with, the deceased, giving particular regard to the spouse of the deceased,
 - (b) the rules, practice and beliefs respecting disposition of human remains and cremated remains followed or held by people of the religious faith of the deceased,
 - (c) any reasonable directions given by the deceased respecting the disposition of his or her human remains or cremated remains, and
 - (d) whether the dispute that is the subject of the application involves family hostility or a capricious change of mind respecting the disposition of the human remains or cremated remains.
- (6) Despite subsections (1) to (3), if the Supreme Court makes an order in favour of a person who has applied to it under subsection (4), that person is deemed to be at the top of the order of priority set out in subsection (1).

Requirement for authorization before funeral services or disposition

8 (1) A funeral provider must not provide funeral services unless the funeral provider has received written authorization from the person who, under section 5 [*control of disposition of human remains or cremated remains*], has the right to control the disposition of the human remains.

(2) Despite subsection (1), a funeral provider may accept an authorization by telephone to begin funeral services if the funeral provider does not dispose of the human remains until the funeral provider receives the written authorization required by subsection (1).

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APPENDIX C:



NOTIFICATION OF EXPECTED DEATH IN THE HOME
To be completed by the Attending Physician

ATTENTION: FUNERAL DIRECTOR

NAME OF FUNERAL HOME			
ADDRESS	CITY	PROVINCE	POSTAL CODE

This is being sent to you in anticipation of death at home in the near future. You have been identified as the funeral home of choice. The family has been instructed to call you one hour after death has occurred for transport of the body.

As the attending physician, I certify that this person is known to me and that to the best of my knowledge and belief this is a natural and expected death. Upon death I authorize you to transfer the body and to complete the Registration of Death. I, or my designate, will complete the Medical Certificate of Death within 48 hours. This authorization shall be in effect for 3 months from the date signed.

PATIENT'S NAME	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH (DD/MM/YYYY)	PERSONAL HEALTH NUMBER
ADDRESS	CITY	PROVINCE	POSTAL CODE
PRECAUTIONS, IF ANY:			

NAME OF ATTENDING PHYSICIAN	MSP NUMBER	PHONE NUMBER
ADDRESS	CITY	PROVINCE POSTAL CODE
COMMENTS		
SIGNATURE OF ATTENDING PHYSICIAN	DATE SIGNED (DD/MM/YYYY)	

AUTHORIZATION OF DISPOSITION FOR EXPECTED DEATH AT HOME

To be completed by the person authorized to control the disposition for the expected death at home of: _____

I certify that I am legally authorized to make decisions after death has occurred and that the plan for management of expected death at home has been discussed and agreed to. I agree to the transfer of the body from the home without pronouncement of death by a health care professional and that we will follow the plan by noting the time of death and agreeing to wait at least one hour from the time of death to call the funeral home for transfer of the body. I agree to indemnify and hold harmless the Funeral Home, its employees and agents, from any liability for claims, damages, costs and expenses of whatever kind or nature (except any claim arising out of or in connection with the wilful misconduct, malfeasance, or negligence of the Funeral Home, its employees and agents) incurred in connection with or arising from the Funeral Home dealing with the Patient's body on my instructions.

- RELATIONSHIP TO DECEASED**
 from the *Cremation, Interment and Funeral Services Act, Sec 5 (1)*:
Authorization of disposition is in order of priority as set out below.
- a) personal representative named in the will;
 - b) spouse of deceased;
 - c) adult child of deceased;
 - d) adult grandchild of deceased;
 - e) if deceased a minor, legal guardian of deceased at time of death;
 - f) parent of deceased;
 - g) adult sibling of deceased;
 - h) adult nephew or niece of deceased;
 - i) adult next of kin of deceased, determined under sections 89 and 90 of the Estate Administration Act;
 - j) minister under the Employment and Assistance Act or the official administrator under the Estate Administration Act;
 - k) an adult person having a personal or kinship relationship with the deceased, other than those referred to in paragraphs (b) to (d) and (f) to (j).

_____ printed name

_____ signature

_____ date signed _____ contact phone number

Form can be downloaded from: <https://www.healthservices.gov.bc.ca/exforms/mspprac/3987fil.pdf>