

**Form 17 – Notification of Death Form –  
Other Medical Practitioner**

Section 81 *Voluntary Assisted Dying Act 2021* (Qld)

**Instructions for completing this form**

About this form

This form must be completed by a medical practitioner who is **not** the person's coordinating practitioner or administering practitioner and who:

- is required to complete a cause of death certificate for a person; and
- knows or reasonably believes that the person self-administered, or was administered, a voluntary assisted dying substance under the *Voluntary Assisted Dying Act 2021* (the Act).

This form must be given to the Voluntary Assisted Dying Review Board to ensure compliance with the Act. It is not a medical record.

**Note:**

- The Act prohibits any reference to voluntary assisted dying being made in the cause of death certificate. The cause of death certificate must state that the cause of death was the disease, illness, or medical condition from which the person suffered ([section 81\(3\)](#) of the Act).
- If the coordinating practitioner completes the cause of death certificate, they must complete Form 16 – Notification of Death Form – Coordinating practitioner / Administering practitioner instead of this form.
- If the person was administered a voluntary assisted dying substance by the administering practitioner, the administering practitioner must complete Form 11 – Practitioner Administration Form instead of this form.

What you need to do

Within **two (2) business days** after deciding whether to accept or refuse the referral for a consulting assessment you must:

1. **Complete** this form
2. **Give** a copy of the completed form to the Voluntary Assisted Dying Review Board.

You must also record the referral and your decision to accept or refuse the referral in the person's [medical record](#).

**Note:** Submitting this form via the [QVAD Review Board IMS](#) is considered giving a copy to the Voluntary Assisted Dying Review Board.

*How to complete and submit this form*

**You do not require access to the QVAD Review Board IMS to submit this form. You will need:**

- A working printer
- The ability to scan.
- 1. **Complete** the form online
- 2. **Print** the form
- 3. **Sign** Part E of the form
- 4. **Scan** the entire form (not just the signature page)
- 5. **Upload** the form to the QVAD Review Board IMS.

If you do not have the technology available to scan the form please contact the Office of the Voluntary Assisted Dying Review Board by email at [VADReviewBoard@health.qld.gov.au](mailto:VADReviewBoard@health.qld.gov.au)

**A. 1. Deceased person's information**

|                              |  |
|------------------------------|--|
| 1.1 VCASE Number (if known): |  |
| 1.2 Title:                   | <input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Ms <input type="checkbox"/> Mrs <input type="checkbox"/> Mx<br><input type="checkbox"/> Other (please specify): |
| 1.3 Family name:             |  |
| 1.4 Given name:              |  |
| 1.5 Preferred name(s):       |  |
| 1.6 Date of birth:           |  |

## 2. Home address

|  |  |
|--|--|
| 2.1 Address line 1:<br>Street address              |  |
| 2.2 Address line 2:<br>Apartment, suite, unit etc. |  |
| 2.3 Suburb:  |  |
| 2.4 State:   |  |
| 2.5 Postcode:                                      |  |

## B. 3. Medical practitioner information

|  |  |
|--|--|
| 3.1 VAD practitioner ID (if applicable): |  |
| 3.2 Ahpra registration number:           |  |
| 3.3 Title:                               | <input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Ms <input type="checkbox"/> Mrs <input type="checkbox"/> Mx<br><br><input type="checkbox"/> Other (please specify): |
| 3.4 Family name:                         |  |
| 3.5 Given name:                          |  |
| 3.6 Practice postcode:                   |  |

## 4. Contact details

|                    |  |
|--------------------|--|
| 4.1 Phone number:  |  |
| 4.2 Email address: |  |

## 5. Preferred mailing address

|  |  |
|--|--|
| 5.1 Address line 1:<br>Street address, P.O. box etc. |  |
| 5.2 Address line 2:<br>Apartment, suite, unit etc.   |  |
| 5.3 Suburb:  |  |
| 5.4 State:   |  |
| 5.5 Postcode:  |  |

## C. 6. Coordinating practitioner information (if known)

|                                     |  |
|-------------------------------------|--|
| 6.1 VAD practitioner ID (if known): |  |
| 6.2 Title:                          | <input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Ms <input type="checkbox"/> Mrs <input type="checkbox"/> Mx<br><br><input type="checkbox"/> Other (please specify): |
| 6.3 Family name:                    |  |
| 6.4 Given name:                     |  |

**D. 7. Person's death**

7.1 Date of person's death: DD/MM/YYYY

7.2 Date became aware of person's death: DD/MM/YYYY

7.3 Date of completion of cause of death certificate: DD/MM/YYYY

7.4 Location of person's death (if known):

☐ Person's private residence

☐ Other private residence (e.g. home of family or friend of person)

☐ Hospital - public

☐ Hospital - private

☐ Palliative Care Unit - public

☐ Palliative Care Unit - private

☐ Hospice

☐ 7.4a Other (please specify):

I know or reasonably believe that the person:

☐ 7.5 self-administered a voluntary assisted dying substance in accordance with the *Voluntary Assisted Dying Act 2021*.

☐ 7.6 was administered a voluntary assisted dying substance in accordance with the *Voluntary Assisted Dying Act 2021*.

7.7 Further details (if required):

|  |
|--|
|  |
|--|

**Note:** the below information is for data collection and analysis purposes only.

7.8 If the person died via self-administration, were any concerns raised about the administration process or the death (if known)?

**E. Signature of medical practitioner**

Signature:

Print name:

Date: DD/MM/YYYY

**Privacy Notice**

The information collected on this form and other forms required under the *Voluntary Assisted Dying Act 2021* (the Act) is collected for, or by Queensland Health through the Voluntary Assisted Dying Review Board (the Board) and the Office of the Voluntary Assisted Dying Review Board for the purpose of meeting its obligations under the Act and may be shared with other government agencies for that purpose and to enable the Board to meet its legislative obligations under other legislation. Information from this form may be provided to registered health practitioners authorised under the Act, QVAD-Support and the person's nominated contact person to facilitate operations under the Act. Personal information collected by Queensland Health will be securely stored and handled in accordance with the *Information Privacy Act 2009* (Qld). For information about how Queensland Health protects your personal information, or to learn about rights to access your own personal information, please see our website at <https://www.health.qld.gov.au/global/privacy> and <https://www.health.qld.gov.au/system-governance/contact-us/access-info/rti-application>.