



Quick Start Guide for Offline Certifiers: Fax Attestation

Vitals Information Partnership (VIP)

Electronic Death Registration System (EDRS)

Revision July 1, 2014



MASSACHUSETTS REGISTRY OF VITAL RECORDS AND STATISTICS

Quick Start Guide for Offline Medical Certifiers

Notes

Notes

Use this page to make notes about your own workflows and processes, which may differ by facility and practice.

Quick Start Guide for Offline Medical Certifiers

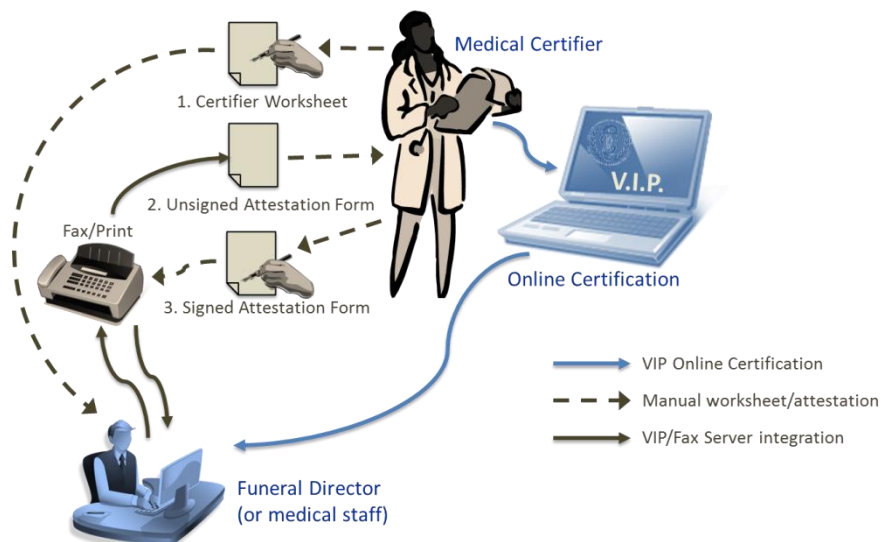
Summary of Steps

You may want to print this page as a quick reference sheet. Note that this summary includes steps for a typical scenario and your own process may vary somewhat depending on internal workflow. While Massachusetts General Law requires completion “immediately,” a good guideline is to have this process completed as soon as possible within 24 hours.

| | |
|---|--|
| 1 | Complete a Death Certificate Certifier Worksheet or similar approved form. The worksheet is available in a form-fillable PDF, or you may print very neatly for data entry. |
| 2 | Deliver the worksheet to your medical staff (if they are online) or to the funeral home. (Your own facility/practice workflow may vary). |
| 3 | Receive the Death Certificate Attestation form. You may receive this by fax or it may be printed and delivered depending on your facility or practice workflow. If a funeral director is doing the data entry, you are more likely to receive this by fax. |
| 4 | Review the Attestation form. <ul style="list-style-type: none">• If the information on the Attestation form was correctly entered, sign and date the Attestation form.• If the information on the Attestation form was incorrectly entered, mark the large checkbox on the form, write changes on the form, and do not sign. |
| 5 | Fax the signed (or corrected) Attestation form to 617-887-8739. The fax is received by an automated document imaging system that attaches an image of the form to the electronic record. The image may only be viewed by authorized EDRS users. (In some facilities and practices, the medical staff will fax the form for you.) |

About EDRS



The Electronic Death Registration System (EDRS) is a module of the larger Vitals Information Partnership (VIP) system that is hosted in the Commonwealth’s secure Virtual Gateway environment. The EDRS replaces the paper process for death certificates. Medical certifiers that do not have a VIP EDRS account will need to use the manual death certificate attestation process. It is highly recommended that “frequent” certifiers use the EDRS system online. The attestation process involves multiple steps, while online certifiers can usually complete a record in just a few minutes.



Quick Start Guide for Offline Medical Certifiers

Death Certificate Medical Certifier Worksheet

Download a form-fillable PDF version of this form at www.mass.gov/dph/vip. If handwritten, please print very neatly. This information must be data entered into the EDRS and you will later verify the accuracy on the Death Certificate Attestation form. Ideally, this 3-step process should only happen once – but, poor handwriting may result in multiple tries.

| | | | |
|--|---|--|--|
|  | | Commonwealth of Massachusetts Registry of Vital Records and Statistics | |
| Form R-360 07012014 | | DEATH CERTIFICATE MEDICAL CERTIFIER WORKSHEET | |
| Please complete the information pertaining to the decedent as well as the cause of death information as this document will be used to create the legal death certificate. PLEASE PRINT NEATLY TO HELP WITH DATA ENTRY. | | | |
| DECEDENT – NAME FIRST | | MIDDLE | LAST |
| Hazel | | Bea | Nutt |
| DATE OF DEATH (Month DD, YYYY) | | SEX | PLACE OF DEATH – CITY/TOWN |
| May 23, 2014 | | Female | Boston |
| MEDICAL RECORD NUMBER | | DATE OF BIRTH (Month DD, YYYY) | |
| ABC1234566789878 | | April 22, 1944 | |
| PLACE OF DEATH | | <input type="checkbox"/> Hospital-Inpatient <input type="checkbox"/> Hospital-ER/Outpatient <input type="checkbox"/> Hospital-DOA <input type="checkbox"/> Decedent's Residence <input checked="" type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home/Long Term Care <input type="checkbox"/> Assisted Living Facility or Rest Home <input type="checkbox"/> Other _____ | |
| HOSPITAL OR OTHER INSTITUTION – NAME (If not in either, provide street and number) | | | |
| Hope Hospice Center | | | |
| PART I – CAUSE OF DEATH – SEQUENTIALLY LIST IMMEDIATE CAUSE THEN ANTECEDENT CAUSES THEN UNDERLYING CAUSE | | | APPX INTERVAL |
| a) Immediate Cause | Pulmonary embolism | | 1 hour |
| b) Due to | Acute myocardial infarction | | 7 days |
| c) Due to | Chronic ischemic heart disease | | >8 years |
| d) Due to | | | |
| PART II – OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH | | M.E. NOTIFIED? | AUTOPSY PERFORMED? |
| Non-insulin dependent diabetes mellitus; obesity; hypertension | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> M.E. <input type="checkbox"/> Priv <input checked="" type="checkbox"/> No |
| AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETING CAUSE OF DEATH? | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |
| MANNER OF DEATH | | | M.E. CASE NUMBER |
| <input checked="" type="checkbox"/> Natural ALL OTHER MANNER OF DEATH CASES ARE REQUIRED TO BE REFERRED TO THE MEDICAL EXAMINER | | | |
| M.E. SECTION ONLY | MANNER OF DEATH | | INJURY AT WORK? |
| | <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Therapeutic Complication <input type="checkbox"/> Could not be determined <input type="checkbox"/> Other (Specify) _____ | | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| | DATE OF INJURY (Month DD, YYYY) | | TIME OF INJURY |
| | | | <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Mil. <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Mil. |
| | PLACE OF INJURY | | TRANSPORTATION INJURY |
| LOCATION/ADDRESS OF INJURY | | <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Not Applicable <input type="checkbox"/> Other (Specify) _____ | |
| M.E. DATE PRONOUNCED (Month DD, YYYY) | | M.E. TIME PRONOUNCED | |
| DESCRIBE HOW INJURY OCCURRED | | <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Military | |
| IF FEMALE, PREGNANCY STATUS AT TIME OF DEATH | | DID TOBACCO USE CONTRIBUTE TO DEATH? | |
| <input checked="" type="checkbox"/> Not pregnant within the past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant within 43 days to 1 year before death <input type="checkbox"/> Unknown, if pregnant in past year | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown | |
| MEDICAL CERTIFIER INFORMATION – NAME/TITLE | | HOUR OF DEATH | |
| Olive Green, D.O. | | 1845 | |
| MEDICAL CERTIFIER INFORMATION – ADDRESS | | LICENSE # | |
| 150 Mt. Vernon Street, Dorchester, MA 02125 | | MA99900099 | |
| MEDICAL CERTIFIER DESIGNATION | | | |
| <input checked="" type="checkbox"/> Certifier in attendance at time of death <input type="checkbox"/> Physician in charge of patient's care <input type="checkbox"/> Nurse Practitioner in attendance at time of death <input type="checkbox"/> Nurse Practitioner in charge of patient's care <input type="checkbox"/> Medical Examiner | | | |
| MEDICAL CERTIFIER FAX NUMBER TO RECEIVE ATTESTATION FORM | | MEDICAL CERTIFIER TELEPHONE NUMBER | |
| 617-740-2711 | | 617-999-9999 | |
| PROVIDER IN CHARGE OF PATIENT'S CARE – NAME/TITLE | | | |
| Myles Long, M.D. | | | |
| RN/PA/NP PRONOUNCEMENT? | IF YES, DATE (Month DD, YYYY) | IF YES, TIME | PRONOUNCER INFORMATION – NAME |
| <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | May 23, 2014 | 1845 | Jacklyn Hyde |
| DATE SIGNED (Month DD, YYYY) | | TITLE | |
| May 24, 2014 | | <input checked="" type="checkbox"/> R.N. <input type="checkbox"/> P.A. <input type="checkbox"/> N.P. | |
| On the basis of examination and/or investigation in my opinion death occurred at the time, date, and place and due to the cause(s) stated. | | Signature and Title of Medical Certifier Required. | |
|  D.O. | | | |

Quick Start Guide for Offline Medical Certifiers

Quick Guide to Worksheet Data Items

A more detailed guide to death certificate data items is available separately. In addition, a cause-of-death online training module is available for continuing education credits. The following summary provides basic information about completing selected worksheet items appropriately:

| | |
|---|---|
| Name of Decedent | Enter the full legal name as you know it. Generational ID is a name suffix, such as "Jr." |
| Date of Death | Preferably, enter as Month DD, YYYY, e.g., May 23, 2014, to avoid transcription error. |
| Sex | Female or Male. |
| Place of Death Town | Enter the proper city/town name where the death occurred. E.g., Boston not Roxbury. |
| Date of Birth | Enter as Month DD, YYYY. If any parts of the date are unknown, enter unknown values with "9"s. E.g., April 99, 1944. |
| Medical Record # | This field is optional, but useful for later look-up when necessary. Note that the "fax" to EDRS is an automated imaging system, and that the resulting image is viewable only to authorized EDRS users. |
| Place of Death – Type | Note that "Decedent's residence" is to be used only for his/her own residence that is not a nursing home, hospice facility, assisted living or rest home. Home hospice may be entered as "Decedent's residence." Another person's residence should be marked "Other." |
| Hospital/Address | If death occurred in a medical/ long-term care facility/ assisted living or rest home, enter the name (e.g., Valley Nursing Home). Specify city/town on the worksheet, if necessary, to distinguish similar sounding facilities. If death occurred elsewhere, such as a private home, enter the full address, including zip code. |
| Cause of Death | List one cause of death per line in Part I, based on facts available to you and your best medical opinion. Line (a) should list the immediate (final) disease or complication directly causing death. Do not list mechanistic causes (e.g., cardiac arrest), as these do not describe the disease process. On line (b), enter the disease or complication that gave rise to the immediate cause. Continue the sequence on lines (c) and (d). Your last line should reflect the "underlying cause." Squeeze in other lines, if necessary, writing "due to" between conditions. |
| Approximate Intervals | Intervals are almost always approximations. Enter an approximate interval for each condition listed in the cause of death sequence. You may enter in many different ways depending on the information available to you. E.g., "8 minutes," ">10 years," "Years." |
| Other significant conditions | List other diseases and conditions that may have contributed to death, but do not directly belong in the sequence of conditions reported in Part I. |
| M.E. notified | Was the medical examiner notified of this case? Mark yes or no. Do not complete death records over which the M.E. took jurisdiction. If you were given a case number, enter in M.E. Case Number. |
| Autopsy Performed | If an autopsy was performed, mark whether private or whether done by the medical examiner. Private includes any non-M.E. autopsy. If there was no autopsy, mark "No." |
| Autopsy findings available? | If you used autopsy findings to complete the death certificate mark "Yes," if not, mark "No." |
| Manner of death | Certifiers other than medical examiners must always mark "Natural." Do not complete the manner of death fields in the Medical Examiner section of this form. "Natural" appears above the medical examiner section. |
| Pregnancy status | Enter whether a female was pregnant at death or any time in the last year. Specific checkbox categories break down the pregnancy intervals to "at death," "within 42 days," and "43 days to one year." This is a new question to comply with CDC national standards. |
| Tobacco Use | Enter whether tobacco use contributed to death as "Yes," "No" or "Probably." Even if this item is checked "Yes," do not exclude tobacco use from the cause of death. |
| Medical Certifier | Enter a full name, title and license number of the physician or nurse practitioner |

