



REPORT OF RECIPIENT DEATH

Reporting Staff/Title _____ Report Date/Time _____

Date/Time Reported to CMH Staff _____ By Whom? _____

1. RECIPIENT'S NAME _____

2. CASE NO. _____

3. D.O.B. _____ AGE _____

4. POPULATION [] MI Adult [] MI Child [] DD Adult [] DD Child

5. DATE OF DEATH _____ 6. TIME OF DEATH _____

7. PLACE OF DEATH (location and address) _____

a. [] Supervision, 24 Hour:
[] Medical Care (non mental health) [] Mental Health Care Setting

b. [] Supervision, Less than 24 Hour:
[] Medical (non-mental health) [] Mental Health

c. [] Independent Living, no supervision

8. RELEVANT OR UNUSUAL CIRCUMSTANCES SURROUNDING DEATH _____

9. CAUSE OF DEATH [] Per Death Certificate (attach) [] Apparent Cause (Death Certificate not yet available)

a. [] EXPECTED DEATH - Natural Causes (indicate one only)

- | | |
|---|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Pneumonia/influenza | <input type="checkbox"/> Diabetes mellitus |
| <input type="checkbox"/> Aspiration or Aspiration pneumonia | <input type="checkbox"/> Endocrine disorders |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Neurological disorders |
| <input type="checkbox"/> Vascular disease | <input type="checkbox"/> Acute bowel disease |
| <input type="checkbox"/> Liver disease/cirrhosis | <input type="checkbox"/> Inanation (starvation, mal-nutrition) |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Complication of treatment. |
| <input type="checkbox"/> Infection, including AIDS | |

b. [] UNEXPECTED DEATH (indicate one only)

- [] Accident [] Suicide [] Homicide [] Cause Unknown or Unreported

10. AUTOPSY REQUESTED BY CMH? [] Yes [] No

(Must request autopsy for any death of a recipients living in a 24 Hour Supervised CMH Direct Operations or Contract Setting, an Inpatient Psychiatric Unit, or if the death occurred at a direct operated or contracted service site)

AUTOPSY PERFORMED / PLANNED (hospital, coroner name, date) _____

11. DIAGNOSIS (Psychiatric and Medical)

- AXIS I _____
 AXIS II _____
 AXIS III _____
 AXIS IV _____
 AXIS V _____

12. MEDICATIONS PRESCRIBED BY CMH WITHIN LAST 30 DAYS _____

13. RECENT CHANGES IN MEDICAL STATUS _____

14. RECENT CHANGES IN PSYCHIATRIC STATUS _____

15. DATE OF MOST RECENT PSYCHIATRIC HOSPITALIZATION (if known) _____

16. DATE OF MOST RECENT MEDICATION REVIEW _____

17. DATE OF MOST RECENT INDIVIDUAL PLAN OF SERVICE _____

18. DATE OF LAST KNOWN CMH SERVICE _____

19. SERVICES THE RECIPIENT WAS RECEIVING AT THE TIME OF DEATH (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Inpatient | <input type="checkbox"/> Children's Foster Care |
| <input type="checkbox"/> Partial Hospitalization | <input type="checkbox"/> Child Caring Institution |
| <input type="checkbox"/> Outpatient | <input type="checkbox"/> Psychosocial Rehabilitation Services |
| <input type="checkbox"/> ACT | <input type="checkbox"/> Day Program |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Prevocational Workshop |
| <input type="checkbox"/> Supports Coordination | <input type="checkbox"/> Supported Employment |
| <input type="checkbox"/> Specialized Residential | <input type="checkbox"/> Community Living Supports |
| <input type="checkbox"/> Other(s) _____ | |

20. PARTIES NOTIFIED OF DEATH (date and time, who contacted)

- Guardian / Parent of minor recipient with legal custody _____
- Executor or next of kin as authorized _____
- Office of Recipient Rights _____
- State/Local Police _____
- FIA AFC/Child Welfare Licensing _____
- FIA Adult Protective Services _____
- FIA Child Protective Services _____
- Others _____

21. SIGNATURE OF REPORTING STAFF/CREDENTIALS _____

22. SUPERVISORY REVIEW (list any actions that have been or will be taken to correct any identified deficiencies found)

22. SIGNATURE OF SUPERVISOR _____

_____ date

Routing: Supervisor
Office of Recipient Rights
Director of Quality Improvement