



DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

DDA Mortality Review Provider Report

NAME OF PERSON COMPLETING FORM (PRINT)	
POSITION/TITLE	
DATE COMPLETED	TELEPHONE NUMBER

Complete upon the death of a person who was receiving services from a contracted or licensed provider or was being transported to/from services provided by contracted or licensed providers. **This report must be sent to the DDA Case Resource Manager (CRM) within (14) calendar days of the person's death.** Note: The person completing the form is not attempting to render a professional opinion and is operating based on the known facts immediately following the death.

I. General Information

DECEASED'S LEGAL NAME (FIRST NAME)	MIDDLE NAME	LAST NAME
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ADDRESS

AGENCY NAME	LOCAL NAME, IF DIFFERENT
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GENDER	ETHNICITY
<input type="checkbox"/> Male	<input type="checkbox"/> African American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American
<input type="checkbox"/> Female	<input type="checkbox"/> Other:

DATE OF DEATH (MM/DD/YYYY)	TIME OF DEATH : <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Estimate	DATE OF BIRTH (MM/DD/YYYY)	AGE
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CITY OF DEATH

APPARENT PRIMARY CAUSE OF DEATH (INCLUDE SOURCE OF INFORMATION)

APPARENT SECONDARY CAUSE OF DEATH (INCLUDE SOURCE OF INFORMATION)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE APPARENT CAUSE LISTED ABOVE (SUCH AS SIGNIFICANT ILLNESS OR DISEASE)

WAS 911 CALLED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	TIME OF CALL : <input type="checkbox"/> AM <input type="checkbox"/> PM	NAME OF CALLER
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CASE REFERRED TO MEDICAL EXAMINER/CORONER <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	AUTOPSY CONDUCTED <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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PLACE OF DEATH (CHECK ALL THAT APPLY)

Deceased's residence Nursing Facility Hospital Adult Family Home

Other (specify): _____

Unknown

Was provider aware of client's location at time of death? Yes No (explain):

TYPE OF RESIDENCE WHERE DECEASED LIVED

- | | | |
|--|--|--|
| <input type="checkbox"/> Supported Living (24/7 on) | <input type="checkbox"/> ARC / Assisted Living | <input type="checkbox"/> Homeless |
| <input type="checkbox"/> Supported Living (24/7 available) | <input type="checkbox"/> Community ICF/ID | <input type="checkbox"/> Own home |
| <input type="checkbox"/> DDA Group Home | <input type="checkbox"/> SOLA | <input type="checkbox"/> Parent's home |
| <input type="checkbox"/> Foster Home/Staffed Residential | <input type="checkbox"/> State Hospital | <input type="checkbox"/> Adult Family Home |
| <input type="checkbox"/> Nursing Facility | | |
| <input type="checkbox"/> Other (specify): _____ | | |

II. Medical Information

CONDITIONS EXISTING PRIOR TO THE PERSON'S DEATH (CHECK ALL THAT APPLY)

- Allergies (type): _____
- Arthritis
- Alzheimer's
- Anemia
- Cancer (type): _____
- Coronary Disease: Cardiopulmonary Congestive Heart Failure Heart Attack (Myocardial Infarction)
- Other
- Diabetes: Insulin Dependent Non-insulin Dependent
- Fracture(s) (type): _____
- Gastric disease
- Hypertension
- Hypotension
- Hypothyroidism
- Notifiable Condition/Communicable Disease (specify): _____
- Renal/kidney disease
- Respiratory disease:
 - Asthma Chronic Obstructive Pulmonary Disease (COPD) Pneumonia Recurrent aspiration
- Seizures
- Sepsis
- Surgical Procedure: _____ Reason: _____
- Surgical Procedure: _____ Reason: _____
- Surgical Procedure: _____ Reason: _____
- Swallowing disorder: G-tube
- Syndrome (specify): _____
- Thrombosis
- Other: _____

Was the deceased treated by any health care provider within 30 days of date of death? Yes No Unknown

Summary / diagnosis:

- Was the deceased hospitalized within 30 days of the date of death? Yes No Unknown
- Was the deceased in hospice care? Yes No Unknown
- Was CPR performed? Yes No Unknown
- Was there a DNR in place?..... Yes No Unknown
- Was there a POLST in place?..... Yes No Unknown

III. Medications

- 1. Was deceased on prescribed medications? Yes No
- 2. List all prescription medications by name, dosage, and frequency.

IV. Mental Health

EXPLAIN ALL YES ANSWERS IN SECTION V BELOW.

	YES	NO	UNKNOWN
While under your care or in your program, had deceased ever attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was death an apparent suicide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

V. Circumstances of Death

BRIEFLY DESCRIBE THE CIRCUMSTANCES OF DEATH AND ANY ADDITIONAL INFORMATION NECESSARY. INCLUDE ANY CONCERNS OF FAMILY OR LEGAL REPRESENTATIVE. SPECIFY POSITION/TITLE OF ALL PERSONS REFERENCED. ATTACH ADDITIONAL PAGES AS NEEDED.

VI. Attachments

Please attach a copy of the most recent IISP or Negotiated Care Plan for the deceased (if applicable).

PROVIDER NAME (PRINT)	SIGNATURE	DATE
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For DDA Case Resource Manager Only (Complete within seven calendar days of receipt and send to the QA Program Manager)

I HAVE REVIEWED THIS REPORT AND THERE IS:

- Additional Information (specify below)
- No additional information

CRM NAME (PRINT)	CRM SIGNATURE	DATE SIGNED
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