

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 7 calendar days of the person's death.** Note: Information provided in this report is the best information available at the time and in no way represents a complete history or a professional medical opinion. 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 / RESIDENTIAL PROVIDER NAME

GENDER <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Female	ETHNICITY <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"/> Other:
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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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PLACE OF DEATH (CHECK ALL THAT APPLY)			
<input type="checkbox"/> Deceased's residence	<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Hospital	<input type="checkbox"/> Hospice Facility <input type="checkbox"/> Unknown
<input type="checkbox"/> Other (specify):			

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

SOURCE OF INFORMATION (CHECK CORRECT BOX)	
<input type="checkbox"/> Death Certificate	<input type="checkbox"/> Medical Provider <input type="checkbox"/> Family or Caregiver
<input type="checkbox"/> Other (specify):	

APPARENT PRIMARY CAUSE OF DEATH

APPARENT SECONDARY CAUSE OF DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE APPARENT CAUSE LISTED ABOVE (SUCH AS SIGNIFICANT ILLNESS OR DISEASE)
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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 AND POSITION OF CALLER
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DEATH CERTIFICATE OR WORKSHEET OBTAINED		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
TYPE OF RESIDENCE WHERE DECEASED LIVED		
<input type="checkbox"/> Supported Living (24/7 on-site)	<input type="checkbox"/> ARC / Assisted Living	<input type="checkbox"/> Homeless
<input type="checkbox"/> Supported Living (24/7 available)	<input type="checkbox"/> Community ICF/IID	<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 / Licensed 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)		
<input type="checkbox"/> Allergies (type): _____		
<input type="checkbox"/> Alzheimer's or Dementia		
<input type="checkbox"/> Anemia / Blood Disorder		
<input type="checkbox"/> Cancer (type): _____		
<input type="checkbox"/> Coronary Disease: <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Heart Attack (Myocardial Infarction) <input type="checkbox"/> Other		
<input type="checkbox"/> Diabetes: <input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Non-insulin Dependent		
<input type="checkbox"/> Fracture(s) (type and body part): _____		
<input type="checkbox"/> Gastric disease (e.g. ulcer, reflux)		
<input type="checkbox"/> Hypertension		
<input type="checkbox"/> Hypotension		
<input type="checkbox"/> Hypothyroidism		
<input type="checkbox"/> Limited mobility / Paralysis		
<input type="checkbox"/> Notifiable Condition / Communicable Disease (specify): _____		
<input type="checkbox"/> Pressure Injury(s) (specify): _____		
<input type="checkbox"/> Renal / kidney disease		
<input type="checkbox"/> Respiratory disease: <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) <input type="checkbox"/> Pneumonia <input type="checkbox"/> Recurrent aspiration <input type="checkbox"/> Ventilator <input type="checkbox"/> BiPap / C-Pap <input type="checkbox"/> Tracheostomy		
<input type="checkbox"/> Seizures		
<input type="checkbox"/> Sepsis		
<input type="checkbox"/> Surgical Procedure: _____ Reason: _____		
<input type="checkbox"/> Surgical Procedure: _____ Reason: _____		
<input type="checkbox"/> Surgical Procedure: _____ Reason: _____		
<input type="checkbox"/> Swallowing disorder: <input type="checkbox"/> Feeding tube <input type="checkbox"/> Dysphagia with diet restriction		
<input type="checkbox"/> Syndrome (specify): _____		
<input type="checkbox"/> Thrombosis or Embolism Type: _____		
<input type="checkbox"/> Other (if related to death): _____		
When was the deceased last treated by any health care provider?		
Summary / diagnosis / date of treatment:		
Hospitalizations (most recent):		
Date: _____	Reason: _____	
Date: _____	Reason: _____	
Date: _____	Reason: _____	

☐ Yes ☐ No

TYPE OF RESIDENCE WHERE DECEASED LIVED

- | | | |
|---|--|--|
| <input type="checkbox"/> Supported Living (24/7 on-site) | <input type="checkbox"/> ARC / Assisted Living | <input type="checkbox"/> Homeless |
| <input type="checkbox"/> Supported Living (24/7 available) | <input type="checkbox"/> Community ICF/IID | <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 / Licensed 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): _____
☐ Alzheimer's or Dementia
☐ Anemia / Blood Disorder
☐ Cancer (type): _____
☐ Coronary Disease: ☐ Arrhythmia ☐ Congestive Heart Failure ☐ Heart Attack (Myocardial Infarction)
 ☐ Other
☐ Diabetes: ☐ Insulin Dependent ☐ Non-insulin Dependent
☐ Fracture(s) (type and body part): _____
☐ Gastric disease (e.g. ulcer, reflux)
☐ Hypertension
☐ Hypotension
☐ Hypothyroidism
☐ Limited mobility / Paralysis
☐ Notifiable Condition / Communicable Disease (specify): _____
☐ Pressure Injury(s) (specify): _____
☐ Renal / kidney disease
☐ Respiratory disease:
 ☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Pneumonia ☐ Recurrent aspiration
 ☐ Ventilator ☐ BiPap / C-Pap ☐ Tracheostomy
☐ Seizures
☐ Sepsis
☐ Surgical Procedure: _____ Reason: _____
☐ Surgical Procedure: _____ Reason: _____
☐ Surgical Procedure: _____ Reason: _____
☐ Swallowing disorder: ☐ Feeding tube ☐ Dysphagia with diet restriction
☐ Syndrome (specify): _____
☐ Thrombosis or Embolism Type: _____
☐ Other (if related to death): _____

When was the deceased last treated by any health care provider?

Summary / diagnosis / date of treatment:

Hospitalizations (most recent):

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Was the deceased in hospice care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Was CPR performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If yes, by who:			
Was there a DNR in place?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Was there a POLST in place?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
III. Medications and Treatments			
1. Was deceased on prescribed medications? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Was nurse delegation in place? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, was the nurse delegator contacted regarding the death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, date of contact:			
3. Was Private Duty Nursing in place? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, was the private duty nurse contacted regarding the death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, date of contact:			
IV. Mental Health			
Did any mental health issues contribute to the death (such as suicide or inability / noncompliance with care)?			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
V. Description of Death			
DESCRIBE THE CIRCUMSTANCES OF DEATH, INCLUDING ILLNESS OR COURSE OF SYMPTOMS THAT LED UP TO THEIR DEATH. INCLUDE INTERVENTIONS SUCH AS CPR OR TRANSFER TO HOSPITAL. ATTACH ADDITIONAL PAGES AS NEEDED.			
VI. Attachments – All boxes must be checked.			
	ATTACHED	N/A	PENDING
Bowel program or protocol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care / progress notes from the previous seven days (prior to death or hospitalization)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Client refusal of Healthcare Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Death certificate / worksheet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Care Protocol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IISP, Nursing Plan of Care, Treatment Plan, or Negotiated Care Plan.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication / Treatment Administration Record (MAR / TAR – signed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Results of any internal investigations related to death or care leading up to death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure protocol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Care Protocol.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specialized diet (if history of swallowing problems)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physicians Orders for Life-Sustaining Treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other; specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PROVIDER NAME (PRINT)	JOB TITLE	DATE	

For DDA Case Resource Manager Only (Complete within five business days following the date of receipt and send to the regional Nursing Care Consultant, and copy regional Quality Assurance Manager and CRM Supervisor)

I have reviewed this report and there is: ☐ Additional Information (specify below) ☐ No additional information

In your opinion, was the death (check all that apply):

Refer to DDA Policy 7.05 Attachment C for definitions of these terms.

☐ Unexpected ☐ Expected / Anticipated ☐ Suspicious ☐ Accidental ☐ Unknown

CRM NAME (PRINT)

DATE REVIEWED