Washington State Department of Social & Health Services
Transforming lives

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

ADDRESS

AGENCY NAME

GENDER
☐ Male
☐ Female

ETHNICITY
☐ African American ☐ Asian/Pacific Islander ☐ Caucasian ☐ Hispanic ☐ Native American
☐ Other:

DATE OF DEATH (MM/DD/YYYY)	TIME OF DEATH	DATE OF BIRTH (MM/DD/YYYY)	AGE
	: ☐ AM ☐ PM ☐ Estimate		

PLACE OF DEATH (CHECK ALL THAT APPLY)
☐ Deceased's residence ☐ Nursing Facility ☐ Hospital ☐ Unknown
☐ Other (specify):
Was provider aware of client's location at time of death? ☐ Yes ☐ No (explain):

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?	TIME OF CALL	NAME OF CALLER
☐ Yes ☐ No ☐ Unknown	: ☐ AM ☐ PM	

CASE REFERRED TO MEDICAL EXAMINER/CORONER	AUTOPSY CONDUCTED
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

TYPE OF RESIDENCE WHERE DECEASED LIVED

- ☐ Supported Living (24/7 on)
- ☐ Supported Living (24/7 available)
- ☐ DDA Group Home
- ☐ Foster Home/Staffed Residential
- ☐ Nursing Facility
- ☐ ARC / Assisted Living
- ☐ Community ICF/IID
- ☐ SOLA
- ☐ State Hospital
- ☐ Homeless
- ☐ Own home
- ☐ Parent's home
- ☐ Adult Family Home
- ☐ 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): _____
- ☐ Pressure Injury(s) (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 (or attach) all prescription medications by name, dosage, and frequency.

3. Was nurse delegation in place? ☐ Yes ☐ No
   If yes, was the nurse delegator contacted regarding the death? ☐ Yes ☐ No
   If yes, date of contact:

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?	☐	☐	☐
Was death an apparent suicide?	☐	☐	☐

V. Description of Death

DESCRIBE THE CIRCUMSTANCES OF DEATH AND ANY ADDITIONAL INFORMATION NECESSARY. INCLUDE ANY CONCERNS OF FAMILY OR LEGAL REPRESENTATIVE. ATTACH ADDITIONAL PAGES AS NEEDED.

VI. Attachments – Please Attach		
☐ Most recent IISP, Nursing Plan of Care, Treatment Plan, or Negotiated Care Plan (if applicable) ☐ Progress notes from the previous 48 hours (prior to death or hospitalization) ☐ Bowel program or protocol (if applicable) ☐ Seizure protocol (if applicable) ☐ Specialized diet (if history of swallowing problems) ☐ Client refusal of Healthcare Services (if applicable) ☐ Other; specify:		
PROVIDER NAME (PRINT)	SIGNATURE	DATE
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