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 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

ADDRESS

AGENCY / RESIDENTIAL NAME | PROVIDERONE ID

GENDER
☐ Male ☐ Other
☐ Female

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

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

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

SOURCE OF INFORMATION (CHECK CORRECT BOX)
☐ Death Certificate ☐ Medical Provider ☐ Family or Caregiver
☐ Other (specify):

SUSPECTED PRIMARY CAUSE OF DEATH (HOW DID YOU COME TO THIS CONCLUSION?)

SUSPECTED SECONDARY CAUSE OF DEATH (HOW DID YOU COME TO THIS CONCLUSION?)

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

WAS 911 CALLED?
☐ Yes ☐ No ☐ Unknown

TIME OF CALL : ☐ AM ☐ PM

POLICE REPORT NUMBER

NAME AND POSITION OF CALLER

TYPE OF RESIDENCE WHERE DECEASED LIVED

- ☐ Supported Living (24/7 on-site)
- ☐ Supported Living (24/7 available)
- ☐ DDA Group Home
- ☐ Foster Home / Licensed 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): _____
- ☐ 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
- ☐ Swallowing disorder: ☐ Feeding tube ☐ Dysphagia with diet restriction
- ☐ Syndrome (specify): _____
- ☐ Thrombosis or Embolism Type: _____
- ☐ Other (if related to death): _____
- ☐ Surgical Procedure: _____ Reason: _____
- ☐ Surgical Procedure: _____ Reason: _____
- ☐ Surgical Procedure: _____ Reason: _____

When was the deceased last treated by any health care provider? List all appointments within the last two months.
Summary / diagnosis / date of treatment:

Hospitalizations (within the last 12 months):

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Was the deceased in hospice care? ..... ☐ Yes ☐ No ☐ Unknown

Was CPR performed? ..... ☐ Yes ☐ No ☐ Unknown

If yes, by who:

Was there a POLST in place? ..... ☐ Yes ☐ No ☐ Unknown

III. Medications and Treatments

1. Was deceased on prescribed medications? ☐ Yes ☐ No
2. Was nurse delegation in place? ☐ Yes ☐ No

   If yes, was the nurse delegator contacted regarding the death? ☐ Yes ☐ No

   If yes, date of contact:

   Date of last nurse delegation home visit:

3. Was Private Duty Nursing in place? ☐ Yes ☐ No

   If yes, was the private duty nurse contacted regarding the death? ☐ Yes ☐ No

   If yes, date of contact:

   Date of last PDN visit:

IV. Mental Health

Did any mental health issues contribute to the death (such as suicide or inability / noncompliance with care)?

☐ Yes ☐ No ☐ Unknown

If yes, describe:

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
Client care / progress notes from the previous 2 weeks (prior to death or hospitalization)	☐	☐	☐
Client refusal of Healthcare Services	☐	☐	☐
Death certificate / worksheet	☐	☐	☐
Individual Instruction and Support Plan, Nursing Plan of Care, or Negotiated Care Plan	☐	☐	☐
Medical care notes (i.e. after visit summaries, nursing visits, home health, hospice, primary care, specialty appointments, Emergency Department, urgent care, hospitalizations (last month)	☐	☐	☐
Medication / Treatment Administration Record (MAR / TAR previous 2 weeks)	☐	☐	☐
Nurse delegation notes (from last home visit)	☐	☐	☐
Physicians Orders for Life-Sustaining Treatment (POLST)	☐	☐	☐
Private Duty Nursing (Nursing Plan of Care and nursing notes – previous 2 weeks)	☐	☐	☐
Results of any internal investigations related to death or care leading up to death	☐	☐	☐
Protocols:			
Bowel program or protocol	☐	☐	☐
Diabetic care protocol / blood sugar tracking records	☐	☐	☐
Seizure protocol	☐	☐	☐
Skin Care Protocol	☐	☐	☐
Specialized diet	☐	☐	☐
Choking/swallowing protocol	☐	☐	☐
Other; specify:	☐	☐	☐

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