DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA) DDA Mortality Review POSITION / TTLE DATE COMPLETED TELEPHONE NUMBER Complete upon the death of a person who was receiving services from a contracted or licensed provider. Transported tofform services provided by contracted or licensed providers. The person completing the form is not attempting to render a professional approximation provided by contracted or licensed providers. The person completing the form is not attempting to render a professional approximation provided by contracted or licenses the score that be sent for AC ase Resource Manager (CRM) within 7 calendar days of the person's death. Note: Information provided by contracted or licenses the score the test is not person completing the form is not attempting to render a professional approximation provided by contracted or licenses the score the listory or a professional approximation and is operating based on the known facts immediately following the death. DECEASED'S LEGAL NAME (FIRST NAME) MIDDLE NAME LAST NAME Caucasian Hispanic GENDER GENCER GENCER	The standarding form DDA Mortality Review Provider Report POSITION / TITLE Date complete upon the death of a person who was receiving services from a contracted or licensed provider or was being transported tolfrom services provided by contracted or licensed providers. This report must be sent to the DDA Cases 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. If General Information DECEASEDS LEGAL NAME (FIRST NAME) MIDDLE NAME LAST NAME DECEASEDS LEGAL NAME (FIRST NAME) MIDDLE NAME Caucasian Hispanic Date OF DEATH (MMDDYYYY) TIME OF DEATH Date OF DEATH (MMDDYYYY) AGE PILCE OF DEATH (AMDDYYYY) TIME OF DEATH Date OF DEATH (MMDDYYYY) AGE PILCE OF DEATH (CHECK ALL THAT APPLY) Caucasian Hispanic Date OF DEATH (MMDDYYYY) AGE PILCE OF DEATH (CHECK ALL THAT APPLY) Caucasian Hispanic Date OF DEATH (MMDDYYYY) AGE PILCE OF DEATH (CHECK CORRECT BOX) Date OF DEATH (MMDDYYYY) IME OF DEATH Date OF DEATH (MMDDYYYY) AGE SUPLCE OF INFORMATION (CHECK CORRECT BOX) Da	<u></u>	NAME OF PERSON COMPLETING FORM (PRINT)						
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NAME AND POSITION OF CALLER		□ Yes □ No □ Unknown : □ AM □ PM	POLICE REPO	DRT NUMBER					

TYPE OF RESIDENCE WHERE DECEASED LIVED	
Supported Living (24/7 on-site)	SS
Supported Living (24/7 available)	
DDA Group Home SOLA Parent's	
·	amily Home
Nursing Facility	
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 (Myocardia	al Infarction
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 Recu	urrent aspiration
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: Surgical Procedure: Reason: Surgical Procedure: Reason:	
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 the last the last treated by any health care provider?	
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Surgical Procedure:	wo months.
Surgical Procedure:	wo months.
Surgical Procedure:	wo months.

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	e with car	e)?		
Yes No Unknown		,		
If yes, describe:				
V. Description of Death				
DESCRIBE THE CIRCUMSTANCES OF DEATH, INCLUDING ILLNESS OR COURSE OF SYMPTOMS THAT LED UP INTERVENTIONS SUCH AS CPR OR TRANSFER TO HOSPITAL. ATTACH ADDITIONAL PAGES AS NEEDED.	TO THEIR	DEAT	H. INCLUDE	
VI. Attachments – All boxes must be checked.				
	ACHED 1	N/A	PENDING	
		N/A	PENDING	
ATTA		N/A	PENDING	
ATTA Client care / progress notes from the previous 2 weeks (prior to death or hospitalization)		N/A	PENDING	
ATTA Client care / progress notes from the previous 2 weeks (prior to death or hospitalization) Client refusal of Healthcare Services		N/A	PENDING	
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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) INO 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	