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|  | | 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)  ARC / Assisted Living  Homeless  Supported Living (24/7 available)  Community ICF/IID  Own home  DDA Group Home  SOLA  Parent’s home  Foster Home / Licensed Staffed Residential  State Hospital  Adult Family 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 (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 | | |