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 PROVIDER NAME

GENDER	ETHNICITY
☐ Male ☐ Other ☐ Female	☐ 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 ☐ 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):

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)

WAS 911 CALLED?	TIME OF CALL	NAME AND POSITION OF CALLER
☐ Yes ☐ No ☐ Unknown	: ☐ AM ☐ PM	

DEATH CERTIFICATE OR WORKSHEET OBTAINED

☐ Yes ☐ No

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
☐ 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? ☐ Yes ☐ No ☐ Unknown

Was CPR performed? ☐ Yes ☐ No ☐ Unknown

If yes, by who:

Was there a DNR in place? ☐ Yes ☐ No ☐ Unknown

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:

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:

IV. Mental Health

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

☐ Yes ☐ No ☐ 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	☐	☐	☐
Care / progress notes from the previous seven days (prior to death or hospitalization)	☐	☐	☐
Client refusal of Healthcare Services	☐	☐	☐
Death certificate / worksheet	☐	☐	☐
Diabetic Care Protocol	☐	☐	☐
IISP, Nursing Plan of Care, Treatment Plan, or Negotiated Care Plan	☐	☐	☐
Medication / Treatment Administration Record (MAR / TAR – signed)	☐	☐	☐
Results of any internal investigations related to death or care leading up to death	☐	☐	☐
Seizure protocol	☐	☐	☐
Skin Care Protocol	☐	☐	☐
Specialized diet (if history of swallowing problems)	☐	☐	☐
Physicians Orders for Life-Sustaining Treatment	☐	☐	☐
Other; specify:	☐	☐	☐

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