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| Transforming Lives | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)**DDA Mortality ReviewProvider 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**[ ]**  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):  |
| 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?**[ ]**  Yes **[ ]**  No **[ ]**  Unknown | TIME OF CALL**:   [ ]**  AM **[ ]**  PM  | NAME AND POSITION OF CALLER |
| DEATH CERTIFICATE OR WORKSHEET OBTAINED**[ ]**  Yes **[ ]**  No  |
| 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**[ ]**  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 **[ ]**  UnknownWas CPR performed? **[ ]**  Yes **[ ]**  No **[ ]**  UnknownIf yes, by who: Was there a DNR in place? **[ ]**  Yes **[ ]**  No **[ ]**  UnknownWas there a POLST in place? **[ ]**  Yes **[ ]**  No **[ ]**  Unknown |
| III. Medications and Treatments |
| 1. Was deceased on prescribed medications? **[ ]**  Yes **[ ]**  No2. 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 PENDINGBowel 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 informationIn 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 |