Developmental Services Reportable Events DEATH REPORT

Date:________________

1. Consumer's name:__________________________________ 2. DOB:______________ 3. Age at time of death:___________

4. Consumer's address:____

5. SSN:_______________ 6. Maine Care I.D. Number:___________________ 7. Guardianship status:_____________________

8. Address/site of death:____

9. Date of death:__________ 10. Approximate time:_________ 11. Service provider or agency:____________________________

12. Please give a brief account of the events immediately preceding and at the time of this person's death. *If you have received a report from the provider or agency, you may attach a copy to this form, in lieu of an account:*_______________________________

13. If you have attached a provider account, please give a contact person and phone number:____________________________

Continue to Page 2

*Your signature and title:*_______________________________

B.D.S. Death Report—Page 2

Consumer's name:__________________________________ **SSN:**____________________ **DOB:**___________________

14. Preliminary cause of death, if known:____

15. Attending physician, if applicable:____

16. Hospital or care facility, if applicable:____

17. E.M.T. Service present at time of death, if applicable:____

18. Responding law enforcement agency, if applicable:____

TO THE BEST OF YOUR KNOWLEDGE:

19. Was this death attended by a physician or other medical personnel? **Y N Unknown**
20. If not, was any other person present at the time? **Y N Unknown**

21. If so, please give a contact person and phone number:_______________________________________

22. Was this death anticipated? **Y N Unknown**
23. Did it appear to be related to a known diagnosis? **Y N Unknown**
24. Did it appear to be related to medication? **Y N Unknown**
25. To substance abuse? **Y N Unknown**
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26. To suicide? **Y N Unknown**
27. To violence or foul play? **Y N Unknown**
28. Did the death occur during the implementation of a behavioral or clinical procedure? **Y N Unknown**

29. In your opinion, are there circumstances to this person's death, other than those listed above, that might call for further information gathering? *If so, please describe here, or provide a separate, brief account to your Supervisor.* _____________

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Notifications: *Please check off those whom you have notified, or who you know to have been notified, of this person's death. If a particular notification is not applicable, write "NA".*

Parent or guardian _____
Correspondent _____
Other concerned family _____ **(Specify)**_________________________________
Adult Protective/Advocacy _____
MR Team Leader or Designate _____
Law Enforcement _____

Signature and title:___________________________

B.D.S. MORTALITY REVIEW

Date:______________

Consumer's name:___________________________________ DOB:___________________ SSN:_______________________

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30. Was the deceased receiving Medicaid Waiver or other funding supports? Specify:________________________________

31. Please give a brief account of any residential moves or major life changes that the deceased had experienced over the past year:____

32. Did the deceased have a regular family physician? Specify:____

33. Did the deceased have an annual physical exam within the past year? Give date, if known:___________________________

34. Was the deceased in the care of any specialists? Specify:____

35. Had the consumer made any Emergency Room visits in the past year? Specify:_____________________________________

36. Any hospitalizations/surgery in the past year? Specify:____

37. Rehabilitation or nursing home stays in the past year? Specify:____

38. Had the consumer received psychiatric or psychological counseling in the past year? Specify:_________________________

CONSUMER'S LEVEL OF INDEPENDENCE:

39. Communication skills:	**Good_____**	**Adequate_____**	**Poor_____**
40. Safety skills:	**Good_____**	**Adequate_____**	**Poor_____**
41. Hygiene/personal care skills	**Good_____**	**Adequate_____**	**Poor_____**
42. Eating and drinking skills	**Good_____**	**Adequate_____**	**Poor_____**
43. General ability to live independently	**Good_____**	**Adequate_____**	**Poor_____**

45. Had the consumer's level of independent functioning changed markedly in the last year? Explain:___________________

DIAGNOSES: *This page must be completed by a Physician or Nurse.*

46. Precise Mental Retardation diagnosis, and cause if known:____

NEUROLOGIC:
47. Cerebral Palsy _____
48. Epilepsy _____
49. Dementia _____
50. Alzheimer's _____
51. Other:________________________________

CARDIOVASCULAR:
52. Coronary Artery Disease_____
53. Congestive Heart Failure_____
54. Hypertension _____
55. Other:________________________________

RESPIRATORY:
56. Pneumonia _____
57. Asthma _____
58. COPD _____
59. Recurrent Infection _____
60. Other:________________________________

GASTROINTESTINAL:
61. GERD _____
62. Dysphagia _____
63. Constipation _____
64. Other:________________________________

MUSCULOSKELETAL:
65. Arthritis _____
66. Osteoporosis _____
67. Other:________________________________

REPRODUCTIVE:
68. Male:_________________________________
69. Female:_______________________________

70. CANCER/NEOPLASM:____

KIDNEY/URINARY:
71. Renal Insufficiency/Failure_____
72. Urinary retention _____
73. Recurrent Infection _____
74. Other:_________________________________

METABOLIC/ENDOCRINE:
75. Diabetes _____
76. Hyperlipidemia _____
77. Hypothyroid _____
78. Hyperthyroid _____
79. Other:_________________________________

80. PSYCHIATRIC DIAGNOSES:____

81. OTHER:____

82. MEDICATION HISTORY. *Attach a copy of the most recent Medication Administration Record (MAR) to this report, or list below. If the reason for the medication is not indicated on the MAE, provide a reason below. Note any medication changes in the month preceding the person's death:* ***Indicate any medication that was started* (S); *dosage changed* (C); *or discontinued* (D) *in the month prior to death.***

MEDICATION	DOSE	FREQUENCY	REASON	Change in last month?

83. Had the consumer been ill in the 24 hours prior to death? Describe:____

84. Was the consumer's physician notified, and if so, what action was taken? Provide time frames:________________________

85. Did the consumer visit an Emergency Room or other medical site in the 24 hours prior to death? If so, describe the circumstances and time frames:____

86. Briefly describe any emergency measures undertaken at the time of the consumer's death:______________________________

87. Has an autopsy been requested?_______ **88. By whom?**_______________ **89. Indicate if attached:**_________

90. Death Certificate requested?_________ **91. Indicate if attached:**___________

Please forward to:
Deb Carron
32 Blossom Lane
SHS 11 2nd Floor Marquardt
Augusta ME 04333