Northern Lakes
COMMUNITY MENTAL HEALTH

# REPORT OF RECIPIENT DEATH

**Reporting Staff/Title** _____ **Report Date/Time** _____

**Date/Time Reported to CMH Staff** _____ **By Whom?** _____

**1. RECIPIENT'S NAME** _____

**2. CASE NO.** _____

**3. D.O.B.** _____ **AGE** _____

**4. POPULATION** [ ] MI Adult [ ] MI Child [ ] DD Adult [ ] DD Child

**5. DATE OF DEATH** _____ **6. TIME OF DEATH** _____

**7. PLACE OF DEATH (location and address)** _____

a. [ ] Supervision, 24 Hour:
[ ] Medical Care (non mental health) [ ] Mental Health Care Setting

b. [ ] Supervision, Less than 24 Hour:
[ ] Medical (non-mental health) [ ] Mental Health

c. [ ] Independent Living, no supervision

**8. RELEVANT OR UNUSUAL CIRCUMSTANCES SURROUNDING DEATH** _____

**9. CAUSE OF DEATH** [ ] Per Death Certificate (attach) [ ] Apparent Cause (Death Certificate not yet available)

a. [ ] EXPECTED DEATH - Natural Causes (indicate one only)

- [ ] Heart Disease
- [ ] Pneumonia/influenza
- [ ] Aspiration or Aspiration pneumonia
- [ ] Lung disease
- [ ] Vascular disease
- [ ] Liver disease/cirrhosis
- [ ] Kidney disease
- [ ] Infection, including AIDS
- [ ] Cancer
- [ ] Diabetes mellitus
- [ ] Endocrine disorders
- [ ] Neurological disorders
- [ ] Acute bowel disease
- [ ] Inanation (starvation, mal-nutrition)
- [ ] Complication of treatment.

b. [ ] UNEXPECTED DEATH (indicate one only)

[ ] Accident [ ] Suicide [ ] Homicide [ ] Cause Unknown or Unreported

**10. AUTOPSY REQUESTED BY CMH?** [ ] Yes [ ] No
(Must request autopsy for any death of a recipients living in a 24 Hour Supervised CMH Direct Operations or Contract Setting, an Inpatient Psychiatric Unit, or if the death occurred at a direct operated or contracted service site)

AUTOPSY PERFORMED / PLANNED (hospital, coroner name, date) _____

**11. DIAGNOSIS (Psychiatric and Medical)**

AXIS I _____
AXIS II _____
AXIS III _____
AXIS IV _____
AXIS V _____

**12. MEDICATIONS PRESCRIBED BY CMH WITHIN LAST 30 DAYS** _____

**13. RECENT CHANGES IN MEDICAL STATUS** _____

**14. RECENT CHANGES IN PSYCHIATRIC STATUS** _____

**15. DATE OF MOST RECENT PSYCHIATRIC HOSPITALIZATION (if known)** _____

**16. DATE OF MOST RECENT MEDICATION REVIEW** _____

**17. DATE OF MOST RECENT INDIVIDUAL PLAN OF SERVICE** _____

**18. DATE OF LAST KNOWN CMH SERVICE** _____

**19. SERVICES THE RECIPIENT WAS RECEIVING AT THE TIME OF DEATH (Check all that apply)**

- [ ] Inpatient
- [ ] Partial Hospitalization
- [ ] Outpatient
- [ ] ACT
- [ ] Case Management
- [ ] Supports Coordination
- [ ] Specialized Residential
- [ ] Children's Foster Care
- [ ] Child Caring Institution
- [ ] Psychosocial Rehabilitation Services
- [ ] Day Program
- [ ] Prevocational Workshop
- [ ] Supported Employment
- [ ] Community Living Supports
- [ ] Other(s) _____

**20. PARTIES NOTIFIED OF DEATH (date and time, who contacted)**

- [ ] Guardian / Parent of minor recipient with legal custody _____
- [ ] Executor or next of kin as authorized _____
- [ ] Office of Recipient Rights _____
- [ ] State/Local Police _____
- [ ] FIA AFC/Child Welfare Licensing _____
- [ ] FIA Adult Protective Services _____
- [ ] FIA Child Protective Services _____
- [ ] Others _____

**21. SIGNATURE OF REPORTING STAFF/CREDENTIALS** _____

**22. SUPERVISORY REVIEW (list any actions that have been or will be taken to correct any identified deficiencies found)** _____

**22. SIGNATURE OF SUPERVISOR** _____ _____
**date**

**Routing: Supervisor**
**Office of Recipient Rights**
**Director of Quality Improvement**