**State of Delaware**

**Department of Health and Social Services**

***CONFIDENTIAL*** **DHSS DEATH REPORT FORM** ***CONFIDENTIAL***

**This form is used to report deaths involving any/all persons 18 years of age and older who received services in a residential setting/facility (licensed or unlicensed) operated by or for any DHSS Division. Pursuant to 42 CFR 482.13(f)(7); 29 Del. C., § 4706; and DHSS PM 46, all deaths related to the use of seclusion or restraint, accidents, homicides, suicides or violence (including those suspected as consumer abuse, neglect, and mistreatment) must be reported. This is a confidential quality assurance document and is peer protected pursuant to 24 Del. C., § 1768. Confidentiality of consumer information is protected under Federal Regulations (42 U.S.C. 4582 and 21 U.S.C. 1175) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 C.F.R. Pts. 160 and 164). Please provide an explanation for any requested information that is unavailable. If additional space is needed, attach separate sheets, referencing the part of the form to which the information pertains. Additional information that is considered relevant, such as client assessments and discharge summaries may be included. Do not file this review report in the consumer’s service record. Please keep a copy of the report for your records.**

**THIS FORM NEEDS TO BE COMPLETED AND SUBMITTED WITHIN TEN (10) BUSINESS DAYS OF THE DEATH. \* SEND COMPLETED FORM BY SECURE EMAIL TO:** complaintandincidentreporting@delaware.gov

 **DHSS DIVISION:** [ ]  **DDDS** [ ]  **DSAAPD** [ ]  **DSAMH**

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| --- | --- |
| **CONSUMER INFORMATION:** |  |
| **NAME OF DECEASED:** Click or tap here to enter text. | **MCI # OF DECEASED/MEDICAID # (if applicable):**Click or tap here to enter text. |
| **GENDER:** [ ]  **MALE** [ ]  **FEMALE****DATE OF BIRTH: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_** **DATE OF DEATH: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_****ADMISSION DATE: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_****Decision Maker (check one):** Own Decision Maker: **\_\_\_\_\_\_\_\_\_\_**Guardian: **\_\_\_\_\_\_\_\_\_\_**DPOA: **\_\_\_\_\_\_\_\_\_\_**Surrogate Decision Maker: **\_\_\_\_\_\_\_\_\_\_** | **PLACE OF DEATH:** [ ]  **RESIDENCE**[ ]  **HOSPITAL \_\_\_\_\_\_\_\_\_\_ (Name of Hospital)** [ ]  **HOSPICE FACILITY/HOME****DHSS Facility:** [ ]  **DHCI** [ ]  **GBHC** [ ]  **DPC** [ ]  **Stockley** [ ]  **OTHER (specify): \_\_\_\_\_\_\_\_\_\_** |
| **REPORTING INFORMATION:** |  |
| **NAME OF REPORTING AGENCY/FACILITY**Click or tap here to enter text. | **ADDRESS OF AGENCY/FACILITY**Click or tap here to enter text. |
| **NAME OF THERAPIST/CASE MANAGER/PHYSICIAN**Click or tap here to enter text. | **NAME OF IMMEDIATE SUPERVISOR**Click or tap here to enter text. |
| **NAME OF PERSON PREPARING REPORT (*Must be a RN)***Click or tap here to enter text. | **DATE/TIME REPORT PREPARED**Click or tap here to enter text. |
| **MOST RECENT DECEASED CONTACT BY DIVISION OR DIVISION CONTRACTOR:****DATE: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_** | **RACE/ETHNICITY (*check all that apply*)**[ ]  **1 WHITE/ANGLO** [ ]  **2 BLACK/AFRICAN AMERICAN** [ ]  **3 ASIA/PACIFIC ISLANDER** [ ]  **4 NATIVE AMERICAN** [ ]  **5 HISPANIC/LATINO** [ ]  **6 OTHER (specify): \_\_\_\_\_\_\_\_\_\_** |
| **POST MORTEM INVESTIGATIONS:****POLICE INVOLVED :** [ ]  **YES** [ ]  **NO** **DETAILS: \_\_\_\_\_\_\_\_\_\_****MEDICAL EXAMINER INVOLVED:** [ ]  **YES** [ ]  **NO** **AUTOPSY COMPLETED:** [ ]  **YES** [ ]  **NO** **TOXICOLOGY REPORT:** [ ]  **YES** [ ]  **NO**  | **DHSS PM 46 INVESTIGATION:** [ ]  **YES** [ ]  **NO** **IF YES, TYPE:** [ ]  **ABUSE** [ ]  **ASSAULT** [ ]  **INJURY** [ ]  **MISTREATMENT** [ ]  **NEGLECT** **SUBSTANTIATED:** [ ]  **YES** [ ]  **NO** [ ]  **RESULTS PENDING****FACILITY REPORT SUBMITTED ON: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_** |
| **CAUSE OF DEATH: (*check all that apply*)** | **CIRCUMSTANCES 72 HOURS PRIOR TO DEATH: (*Attach* *documents including medical information, police reports etc., if available*)** |
| [ ]  **ACCIDENT:**[ ]  **FALL** [ ]  **HOUSEHOLD** [ ]  **MOTOR VEHICLE** [ ]  **ASPERATION/CHOKING**[ ]  **OTHER: \_\_\_\_\_\_\_\_\_\_**[ ]  **MEDICAL REASON:**[ ]  **CANCER** [ ]  **DIABETES** [ ]  **DEMENTIA** [ ]  **HEART DISEASE** [ ]  **KIDNEY DISEASE** [ ]  **LIVER DISEASE** [ ]  **PNEUMONIA** [ ]  **RESPIRATORY DISEASE /COPD** [ ]  **STROKE** [ ]  **OTHER: \_\_\_\_\_\_\_\_\_\_** [ ]  **DRUG OVERDOSE:** [ ]  **ACCIDENTIAL** [ ]  **SUICIDE**[ ]  **PRESCRIPTION DRUG** [ ]  **NONPRESCRIPTION DRUG**[ ]  **SUICIDE: Method: \_\_\_\_\_\_\_\_\_\_** [ ]  **HOMICIDE/VIOLENCE**[ ]  **EXPECTED or** [ ]  **UNEXPECTED:** **Explain: \_\_\_\_\_\_\_\_\_\_** | Click or tap here to enter text. |
| **MEDICAL DIAGNOSES AT TIME OF DEATH:** **(*check all that apply*)** | **PSYCHIATRIC DIAGNOSES AT TIME OF DEATH:** |
| [ ]  **ALCOHOL RELATED DISEASE** [ ]  **CANCER** [ ]  **DEMENTIA** [ ]  **DIABETES** [ ]  **HEART DISEASE** [ ]  **HEPITITIS C** [ ]  **HIV** [ ]  **INFECTIOUS DISEASE(other)** [ ]  **HYPERLIPIDEMIA** | [ ]  **HYPERTENSION** [ ]  **KIDNEY DISEASE** [ ]  **LIVER DISEASE** [ ]  **OBESITY** [ ]  **PERIPHERAL VASCULAR DISEASE**[ ]  **PNEUMONIA** [ ]  **RESPIRATORY DISEASE** [ ]  **STROKE** [ ]  **OTHER: \_\_\_\_\_\_\_\_\_\_** | [ ]  **ANXIETY DISORDER**[ ]  **BIPOLAR DISORDER**[ ]  **DEPRESSIVE DISORDER**[ ]  **PTSD**[ ]  **PERSONALITY DISORDER**[ ]  **SCHIZOPHRENIA/PSYCHOTIC DISORDER**[ ]  **OTHER: \_\_\_\_\_\_\_\_\_\_** |
| **SUBSTANCE ABUSE HISTORY** | **TOBACCO USE** |
| **HISTORY OF ALCOHOL ABUSE:** [ ]  **YES** [ ]  **NO****HISTORY OF DRUG ABUSE:** [ ]  **YES** [ ]  **NO****INTERVENOUS DRUG ABUSE:** [ ]  **YES** [ ]  **NO** | **CURRENT SMOKER:** [ ]  **YES** [ ]  **NO****HISTORY OF SMOKING:** [ ]  **YES** [ ]  **NO****OTHER TOBACCO USE HISTORY:** [ ]  **YES** [ ]  **NO** |
| **LIST PSYCHOTROPIC/MEDICAL MEDICATIONS: *(Name and Dosage)*** | **PSYCHOSOCIAL RISK FACTOR:** |
| Click or tap here to enter text. | **\_**Click or tap here to enter text. | Click or tap here to enter text. | [ ]  **HISTORY OF ABUSE**[ ]  **PAST HOMELESSNESS**[ ]  **LEGAL ISSUES**[ ]  **OTHER: \_\_\_\_\_\_\_\_\_\_** |
| **REVIEWED BY FACILITY/CONTRACT PROVIDER DIRECTOR:****NAME: \_\_\_\_\_\_\_\_\_\_****DATE: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_****REVIEWED BY DHSS FACILITY MEDICAL DIRECTOR (if applicable):** **NAME: \_\_\_\_\_\_\_\_\_\_****DATE: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**  | **REVIEWED BY DIVISION DIRECTOR:****NAME: \_\_\_\_\_\_\_\_\_\_****DATE: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_** |