State of Delaware
Division of Substance Abuse and Mental Health

CONFIDENTIAL **DSAMH Death Report Form** *CONFIDENTIAL*

This form is used to report deaths involving any/all persons receiving state funded mental health and/or substance abuse services. 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. Send or fax form to: Director of Community Mental Health Services, Main Administration Bldg., 19 01 N. DuPont Hwy., New Castle DE 19720. Fax: 302-255-4499.

MODALITY: ☐ **MENTAL HEALTH CONDITION** ☐ **SUBSTANCE USE CONDITION**

SEX ☐ **MALE** ☐ **FEMALE**

CONSUMER INFORMATION:	
NAME OF CONSUMER	**RECORD # OF CONSUMER**
DATE OF BIRTH: ___/___/_____ **DATE OF DEATH:** ___/___/_____ **ADMISSION DATE:** ___/___/_____	**LAST KNOWN ADDRESS**
REPORTING INFORMATION:	
NAME OF REPORTING FACILITY	**ADDRESS**
NAME OF THERAPIST/CASE MANAGER	**NAME OF IMMEDIATE SUPERVISOR**
NAME OF PERSON PREPARING REPORT	**DATE/TIME REPORT PREPARED**
MOST RECENT CONSUMER CONTACT **DATE:** ___/___/_____ **METHOD:** ☐ **FACE TO FACE** ☐ **PHONE** ☐ **CORRESPONDENCE**	**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*)**_____
CAUSE OF DEATH: (*check all that apply*)	**CIRCUMSTANCES/LOCATION (*attach reporting documents*)**
☐**TERMINAL ILLNESS (*specify*:**_____**)** ☐**ACCIDENT** ☐**NATURAL CAUSES** ☐**DRUG OVERDOSE** ☐**SUICIDE** ☐**HOMICIDE/VIOLENCE** ☐**EXPECTED or** ☐**UNEXPECTED** **(*explain*:**_____ _____ _____**)**	_____ _____ _____ _____ _____ _____ _____ _____ _____

(cont'd) ☐ **COMPLICATION OF CHRONIC/ACUTE MEDICAL CONDITION** ☐ **WITHIN 7 DAYS OF A RESTRICTIVE INTERVENTION** ☐ **UNKNOWN CAUSE**	*(cont'd)* _____ _____ _____ _____ _____ _____
PRIMARY CLINICAL / MEDICAL DIAGNOSES AT	**TIME OF DEATH:**
AXIS I:	**AXIS II:**
AXIS III:	**AXIS IV:**
MOST RECENT GAF:	**GAF DATE**
PSYCHOTROPIC/MEDICAL MEDICATIONS (*please list all*) _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	**TREATMENT RECEIVED PRIOR TO DEATH:** ☐ **COUNSELING/THERAPY** ☐ **SMOKING CESSATION** ☐ **GROUPS** ☐ **MEDICATION MANAGEMENT** ☐ **CASE MANAGEMENT** ☐ **REHABILITATION (*specify)*** _____ _____
PHARMACOLOGICAL AGENTS ADJUNCT TO SUSTANCE USE TREATMENT (*please list: naltrexone, methadone, etc.)* _____ _____ _____	**PCP NAME** _____ **DATE OF LAST 2 MEDICAL EXAMS:** ___/___/_____ **AND** ___/___/_____ ☐ **ACTIVE SMOKER QUANTITY PER DAY** _____
COMPLIANCE WITH TREATMENT: **MEDICAL:** ☐ **COOPERATIVE** ☐ **SPORADIC** ☐ **QUESTIONABLE** ☐ **UNCOOPERATIVE** **PSYCHIATRIC:** ☐ **COOPERATIVE** ☐ **SPORADIC** ☐ **QUESTIONABLE** ☐ **UNCOOPERATIVE** **SUBSTANCE USE:** ☐ **COOPERATIVE** ☐ **SPORADIC** ☐ **QUESTIONABLE** ☐ **UNCOOPERATIVE**	**POST MORTEM INVESTIGATIONS:** ☐ **POLICE** **DATE CONTACTED:** ☐ **MEDICAL EXAMINER** **DATE CONTACTED:** ☐ **DHSS PM 46** **DATE INITIATED:**
NAME OF PERSON COMPLETING REPORT:	**NAME OF AGENCY SUPERVISOR:**