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

CONSUMER INFORMATION:	
NAME OF DECEASED	**MCI # OF DECEASED/MEDICAID # (if applicable)**
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	**ADDRESS OF AGENCY/FACILITY**
NAME OF THERAPIST/CASE MANAGER/PHYSICIAN	**NAME OF IMMEDIATE SUPERVISOR**
NAME OF PERSON PREPARING REPORT (*Must be a RN*)	**DATE/TIME REPORT PREPARED**
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*)

☐**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:_____

_____

_____

CIRCUMSTANCES 72 HOURS PRIOR TO DEATH: (*Attach documents including medical information, police reports etc., if available*)

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MEDICAL DIAGNOSES AT TIME OF DEATH: (*check all that apply*)

☐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
_____

PSYCHIATRIC DIAGNOSES AT TIME OF DEATH:

☐ANXIETY DISORDER
☐BIPOLAR DISORDER
☐DEPRESSIVE DISORDER
☐PTSD
☐PERSONALITY DISORDER
☐SCHIZOPHRENIA/PSYCHOTIC DISORDER
☐OTHER _____

SUBSTANCE ABUSE HISTORY

HISTORY OF ALCOHOL ABUSE: ☐ YES ☐ NO
HISTORY OF DRUG ABUSE: ☐ YES ☐ NO
INTERVENOUS DRUG ABUSE: ☐YES ☐NO

TOBACCO USE

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:

☐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:_____