KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

RECIPIENT DEATH REPORT

Please fill out this form completely. If there are areas left blank, a CMH staff member may be contacting you for further information. Thank you.

NOTE: ANY DOCUMENTS THAT ARE NOTED ON THIS FORM MUST BE ATTACHED.

VERBAL REPORTING (Note: Deaths are to be immediately reported verbally to CMHSP)
Date and Time of Verbal Report: ____ / ____ / ____ ____ : ____ ☐ **AM** ☐ **PM**
Name of individual who made report: _____
Names of CMH staff contacted: _____

DATE OF THIS REPORT ____ / ____ / ____

PERSONAL INFORMATION
Recipient Name/ID#: _____ Sex: Male ☐ Female ☐
Recipient Birth Date: ____ / ____ / ____ Age: ____

DIAGNOSES
Service population: ☐ MIA ☐ DDA ☐ SED ☐ DDC
Psychiatric Diagnosis: _____
Developmental Diagnosis: _____
Medical Diagnosis: _____

HOSPITAL/NURSING HOME INFORMATION
All CMH funded services the recipient was receiving: _____
Discharge date: of last MDHHS psychiatric hospitalization: ____ / ____ / ____ ☐ N/A
(Includes only state facilities such as KPH; does not include private psychiatric hospitalization)
Discharge date from last hospital/nursing home stay: ____ / ____ / ____
Name of residence prior to hospitalization/admittance to nursing home: _____
Length of time resided in nursing home: ____ Years ____ Months
I-Team ☐ Yes ☐ No 24-Hour Care: ☐ Yes ☐ No Outpatient: ☐ Yes ☐ No

INFORMATION PERTAINING TO DEATH
Date of death: ____ / ____ / ____ Time of Death ____ : ____ ☐ **AM** ☐ **PM**

Autopsy requested? ☐ Yes ☐ No
If **yes**, who requested the autopsy? _____
NAME RELATIONSHIP

Medical Examiner (date & time) ____ / ____ / ____ ____ : ____ ☐ **AM** ☐ **PM**
Family/Guardian contacted (date & time) ____ / ____ / ____ ____ : ____ ☐ **AM** ☐ **PM**

Name of Family/Guardian contacted: _____ Relationship: _____

Place of death: _____
How long had recipient been at this location? ____ Years ____ Months

1 Cause of Death
- ☐ Suicide
- ☐ Homicide
- ☐ Accident: While under program supervision
- ☐ Accident: Not under program supervision
- ☐ Natural Causes (refers to deaths occurring as a result of a disease process in which death is an anticipated outcome)

2 Additional information regarding cause of death:

_____
_____
_____

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3 Describe circumstances prior to death:

4 If **suicide**:
- a. Was there a known risk of suicide? ☐ Yes ☐ No
- b. If there was a known risk, precautionary measures taken were: _____
- c. Method of suicide: _____

5 Medical History (include any physical/mental decompensation noted):

6 Medical condition and treatment immediately preceding death:

7 List and attach:
- a. Medical Documentation: _____
- b. Lab Test results: _____
- c. EKGs and X-Rays _____
- d. Supporting Medical Diagnosis: _____

(PLEASE INCLUDE ALL OF THE ABOVE WHEN POSSIBLE)

8 Dates of last blood level testing and results:
_____ / _____ / _____ Results: _____
_____ / _____ / _____ Results: _____

9 Medication – Dosage, route and time administered (last 24 hours):
Medication _____ Time administered: _____ : _____ ☐ **AM** ☐ **PM**
Medication _____ Time administered: _____ : _____ ☐ **AM** ☐ **PM**
Medication _____ Time administered: _____ : _____ ☐ **AM** ☐ **PM**
Medication _____ Time administered: _____ : _____ ☐ **AM** ☐ **PM**

10 Additional information:

11 Note any debriefings related to the death that have occurred: _____

Signature Title

Agency/Program Address Phone

PLEASE SEND TO OFFICE OF RECIPIENT RIGHTS WITHIN 24 HOURS OF RECIPIENT'S DEATH