INTEGRATED SERVICES OF KALAMAZOO

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