MACOMB COUNTY COMMUNITY MENTAL HEALTH-SUBSTANCE USE SERVICES DEPARTMENT
REPORT OF DEATH FORM

Provider Name:_____ **Primary Therapist Name:**_____

Consumer Name:_____ **DOB:**_____

Case # _____ **SSN #** _____ **Gender: M / F /** _____

Weight: _____ **Height:** _____

Level of Treatment: ☐ OP ☐ OMT ☐ IOP ☐ W/M ☐ Residential **Admission Date:** _____

Number of Visits:_____ **Last Treatment Contact Date:** _____

Status of Case at Time of Death: ☐ Open ☐ Closed; If Closed, Date of Discharge: _____

Clinical Progress: Prior to the report of death, consumer was: ☐ Abstinent/Compliant with Treatment

☐ Abstinent/Non-Compliant ☐ Relapsed/Compliant ☐ Relapsed/Non-Compliant ☐ Unknown

Clinically/behaviorally how was consumer doing just prior to report of death, or if discharged, just prior to discharge?

☐ Greatly Improved ☐ Moderately Improved ☐ Slightly Improved ☐ Unchanged

☐ Regressed ☐ Unknown Explain:_____

Most Recent DSM-V Diagnosis:

Primary_____

Secondary_____

Tertiary_____

_____

_____

Medical: Primary Care Physician (PCP): _____

Any Hospitalizations: Y / N (if yes, when & why)_____

☐ Nicotine Use ☐ Diabetes ☐ Hypertension

Medications: Include all currently prescribed or OTC medications used for medical or psychiatric treatment.

_____

(Medication) (Rx/OTC) (Name Prescribing MD) (Clinic or Private/HMO MD) (Date Most Recent Med Rev.)

_____

(Medication) (Rx/OTC) (Name Prescribing MD) (Clinic or Private/HMO MD) (Date Most Recent Med Rev.)

Use reverse side for additional medications:

Date of Death:_____ **Age at Time of Death:**_____

How and when (date) was program notified of death?_____

Place and Circumstance of Death (Include whether or not substance use was involved):_____

_____

(Use reverse side for additional information)

Preliminary Cause of Death:

☐ Suicide ☐ Homicide ☐ Accident ☐ Overdose ☐ Natural Causes/Pre-existing Illness

☐ Undetermined/Pending ☐ Other (Explain/Clarify):_____

Additional Comments/Relevant Information Regarding Consumer Death:_____

_____

(Use reverse side for additional comments/information):

Actions taken by Program After Report of Death: (Check all that Apply)

☐ Incident Review ☐ Mortality Review ☐ Sentinel Event Review

☐ Root Cause Analysis ☐ Other (describe):_____

☐ None (if none, explain): _____

Actions Taken as a *Result of the Investigation* of Consumer Death:

_____

(Supervisory Staff Completing Report) **(Date)**

Additional Comments: