DEATH REPORT FORM

Send typed form to DBHDDincidents@dbhdd.ga.gov **Incident #**

Date of Death ______ **Date of Death:** ______

Date of Discovery of Death: ______ **Time of Death:** ______

Community Provider reporting: ______

If reporting provider is a subcontractor, who is primary contractor? ______

DBHDD Region # ______ **Person Completing Report** ______

Contact Person: ______ **Contact Person phone #:** ______

Name of site and/or specific location where death occurred (i.e.: Hospital Name, Unit name/number, Name of CLA/PCH, etc):

______

Check appropriate box Community Residential Program ☐ CLA ☐ Crisis Stabilization ☐ Crisis Support Home ☐ Day Program ☐ Host Home ☐ In Community ☐ Local Hospital ☐ PCH ☐ PRTF ☐ Personal Residence ☐ Respite ☐ TIS ☐

Other *(please specify)*: ______

Individual information

Name (first, last) ______ **DOB** ______ **Age at Time of Death** ______ **Sex** Female ☐ Male ☐

Address ______ **City** ______ **State** GA **Zip** ______ **County** ______

Medicaid Waiver? Yes ☐ No ☐ **CID/MHID #** ______ **SS#** ______ **Race** ______

Admission Date ______ **Disability:** MH ☐ DD ☐ AD ☐ **Check box if participant directed services** ☐

List agency services in which individual was enrolled:

How was death discovered?

______

Date of last contact with individual: ______ **Reason for last contact:** ______

Medical History ***(check all that apply)***

Accidents ☐ Bowel Obstruction ☐ Cancer ☐ Cerebrovascular disease (stroke) ☐ Choking ☐ Chronic Liver Disease ☐ Chronic Lower Respiratory Disease ☐ Diabetes ☐ Diseases of Heart ☐ Hypertension ☐ Medication-Related ☐ Pneumonia/Influenza ☐ Septicemia ☐ Suicide ☐ Unknown ☐

Has autopsy been ordered? Yes ☐ No ☐	**If not state reason:**

Cause of death, when known:

______

Were there unusual circumstances surrounding death (i.e. accident, homicide, etc)? Yes ☐ No ☐ **If yes, please describe.**

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Medications given to individual one (1) week prior to the point of death

Medication	Dose	Route	Frequency

Category of Death

☐	Category I-Death-Unexpected
☐	Category I-Suicide
☐	Category II-Death-Expected
☐	Category III-Death

Brief description of incident-(include who; what; where; when; how; and any precipitating factors that may have contributed to the death, including any medical conditions that have been diagnosed-

Notifications

Agency	Name	Date	Time	Method of Notification
Adult Protective Services				
CPS/DFCS				
Healthcare Facility Regulation				
Support Coordinator/Planning List Administrator				
Family/Legal Guardian				
Other				

Managerial Review

Community provider staff/title: ____________________

Date: ____________________

☐ **By checking this box, I attest that the above entry for community provider staff/title verifies my review of the incident**