RECIPIENT DEATH REPORT

Date of Report:_____

Patient's Name:_____ Case:_____ DOB:_____

Sex:_____ Race:_____ Caucasian_____ Date & Time of Death:_____

Admission Date: _____ Classified 1) Critically Ill_____
2) Seriously Ill_____
3) Chronic Seriously Ill_____

Legal Admission Status:_____ Autopsy Requested:_____

Place of Death:_____

If place was not a DHHS hospital/center list date of last day In DHHS hospital or center:

_____
_____
_____

1. Death Expected:_____ Unexpected:_____

2. Diagnosis: (Medical&Psychiatric)
_____

3. Cause of Death:_____

4. Relevant Past Medical History:_____

_____

5. List Surgical Procedures During Past Year:_____

6. Recent Changes in Medical Status:_____

7. Summary of Medical Condition and Treatment Preceding Death (if transferred to a General Hospital Include Date and Time)._____

_____

_____

8. Medications (Dose and Time Administered):

_____

(A) Last 24 Hours:_____

(B) Last 30 Days:_____

_____

_____

9. Circumstances Surrounding Death, Including Treatment (if Suicidal Death, Include Indication of Need For Precautions, Precautionary Measures Taken, And What Was Used By The Patient, If Accidental Death, Include Type of Accident And How It Occurred.

_____

_____

_____

_____

_____

_____

10. Preliminary Autopsy Report: _____

_____

Attach Additional Sheets As Needed

_____ _____

Recipient Rights Officer Pivotal Clinical Director