



# Death Report

State of Minnesota  
Office of the Ombudsman for Mental Health and Developmental Disabilities  
FAX: 651-797-1950



Date: \_\_\_\_\_

County: \_\_\_\_\_

## Client Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Name of Residential Facility/Provider \_\_\_\_\_

Client resided prior to death \_\_\_\_\_

Street Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Gender: \_\_\_M \_\_\_F **Client Date of Birth:** \_\_\_/\_\_\_/\_\_\_

Type of License #: \_\_\_\_\_ Was client on or eligible for Medical Assistance? \_\_\_Yes \_\_\_No

Ethnic: \_\_\_\_\_ African American \_\_\_\_\_ Native American \_\_\_\_\_ Asian  
\_\_\_\_\_ SE Asian \_\_\_\_\_ Hispanic \_\_\_\_\_ Caucasian  
\_\_\_\_\_ Unknown

Guardianship: \_\_\_\_\_ None \_\_\_\_\_ Private Guardian/Conservator  
\_\_\_\_\_ Public Guardian/Conservator \_\_\_\_\_ Representative Payee  
\_\_\_\_\_ Power of Attorney \_\_\_\_\_ Unknown  
\_\_\_\_\_ Parent

Legal Status: \_\_\_\_\_ Informal Admin (voluntary) \_\_\_\_\_ Stay of Commitment  
\_\_\_\_\_ Committed \_\_\_\_\_ Psychopathic Personality  
\_\_\_\_\_ Emergency Hosp/Court Hold \_\_\_\_\_ Rule 20 or 27  
\_\_\_\_\_ Temp Placement \_\_\_\_\_ Respite Care  
\_\_\_\_\_ Juvenile Court Comm \_\_\_\_\_ Inform Juvenile Admin by Parent  
\_\_\_\_\_ Provisional Discharge \_\_\_\_\_ None

Disability: \_\_\_\_\_ DD \_\_\_\_\_ MI \_\_\_\_\_ CD \_\_\_\_\_ ED  
\_\_\_\_\_ MI&D \_\_\_\_\_ PP \_\_\_\_\_ MI/CD \_\_\_\_\_ MI/DD

## Reporter Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Title: \_\_\_\_\_

Street Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Death Information**

Facility where death occurred: \_\_\_\_\_

Street Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date admitted to place of death: \_\_\_\_\_

Date of Death: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Time of Death: \_\_\_\_\_ a.m. or p.m.

Death Type: (circle one):  Natural  Accident  Undetermined  
 Suicide  Homicide

Was death expected?  Yes  No DNR/DNI Order:  Yes  No

Limited Treatment:  Yes  No Autopsy:  Yes  No

Cause of Death: \_\_\_\_\_

**Diagnosis**

Axis I (Clinical Syndromes): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Axis II (Developmental/Personality Disorders): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Axis III (Physical Disorders): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Current Medications and Dosages: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Other Agencies Involved/Referred to/Notified:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Legal          | <input type="checkbox"/> County         | <input type="checkbox"/> MH Association             |
| <input type="checkbox"/> Administration | <input type="checkbox"/> State Agency   | <input type="checkbox"/> Medical                    |
| <input type="checkbox"/> Ombudsman      | <input type="checkbox"/> Private Agency | <input type="checkbox"/> Other Government           |
| <input type="checkbox"/> DHS            | <input type="checkbox"/> Treatment Team | <input type="checkbox"/> Adult/Child Protection/CEP |
| <input type="checkbox"/> OHFC           |   |   |

Circumstances surrounding death: \_\_\_\_\_  
(may send incident report)

\_\_\_\_\_  
\_\_\_\_\_