MINNESOTA
OFFICE OF OMBUDSMAN
FOR MENTAL HEALTH AND
DEVELOPMENTAL DISABILITIES

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https://mn.gov/omhdd

Death Report

Date of report: _____

(If all information is not available within 24 hours, please submit the report with the information you have.)

CLIENT INFORMATION

First Name:_____ MI:_____ Last Name:_____

Client Facility Name (if applicable): _____

Address: _____

_____ Apt/Suite#: _____

City: _____ County: _____ State: _____ Zip Code: _____

Gender: ☐ Female ☐ Male ☐ Other Date of Birth: _____

Date of Death: _____ Time of Death: _____ ☐ AM ☐ PM

Ethnicity:

- ☐ African
- ☐ African American
- ☐ American Indian or Native Alaskan
- ☐ Asian
- ☐ Caucasian or White
- ☐ Choose Not to Respond
- ☐ Hispanic or Latino
- ☐ Other
- ☐ Pacific Islander or Native Hawaiian

Legal Representative (check all that apply):

- ☐ Health Care Agent
- ☐ Health Care Directive
- ☐ None
- ☐ Nonparent/Relative
- ☐ Parent
- ☐ Power of Attorney
- ☐ Power of Attorney for Health Care Agent
- ☐ Private Conservator
- ☐ Private Guardian
- ☐ Public Guardian
- ☐ Representative Payee
- ☐ Substitute Decision Maker (Commitment Statute 253B.092)
- ☐ Tribal Custody

Legal Status at Time of Death (check all that apply):

- ☐ Committed - Chemical Dependency (CD)
- ☐ Committed - Developmental Disability (DD)
- ☐ Committed - Mentally Ill (MI)
- ☐ Committed - Mentally Ill and Dangerous (MI&D)
- ☐ Committed - Sexual Psychopathic Personality (SPP)
- ☐ Committed - Sexually Dangerous Person (SDP)
- ☐ Emergency Hold Court Hold
- ☐ Incarcerated (Jail or Prison)
- ☐ Informal Juvenile Placement by Parents
- ☐ Juvenile Court Placement
- ☐ None
- ☐ Probation
- ☐ Provisional Discharge
- ☐ Rule 20
- ☐ Stay of Commitment
- ☐ Unknown
- ☐ Voluntary Admission

Client Category (check all that apply):

- ☐ Brain Injury
- ☐ Chemical Dependency/Substance Use Disorder
- ☐ Developmental/Intellectual Disabilities
- ☐ Emotional Disturbance
- ☐ Mental Illness
- ☐ Mentally Ill and Dangerous
- ☐ Other
- ☐ Sex Offender

REPORTER INFORMATION

First Name:_____ Last Name:_____

Title:_____

Agency/Program Name (if applicable): _____

Address:_____

_____ Apt/Suite#: _____

City: _____ State: _____ Zip:_____

Contact Number: _____ Fax Number: _____

Other Agencies Involved/Referred to/Notified (check all that apply):

- ☐ Administration
- ☐ Adult or Child Protection or CEP
- ☐ Attorney Legal
- ☐ County Agency
- ☐ Facility or Program or Agency Staff
- ☐ Guardian or Legal Representative
- ☐ Hospital Review Board
- ☐ Law Enforcement
- ☐ Licensing Agency
- ☐ Medical Resources Health Care Provider
- ☐ Office of Health Facility Complaints (OHFC)
- ☐ Advocacy/Ombudsman Agency
- ☐ Other – describe_____
- ☐ Other Advocacy or Ombudsman Agency
- ☐ Private Agency
- ☐ State Agency
- ☐ Treatment Team

DEATH INFORMATION

Did the Person die where they lived? ☐ Yes ☐ No

If not, Name of Agency, Facility or Program where death occurred (if applicable):

_____

Address: _____

_____

City:_____State:_____Zip:_____

Telephone Number: _____ Fax: _____ County:_____

Date admitted to place of death:_____

Death Type (check one):

- ☐ Accident
- ☐ Could not be determined
- ☐ Homicide
- ☐ Natural
- ☐ Pending investigation
- ☐ Suicide

Was death expected? ☐ Yes ☐ No

Hospice Care: ☐ Yes ☐ No

Limited Treatment: ☐ Yes ☐ No

DNR/DNI Order: ☐ Yes ☐ No ☐ Unknown

Autopsy ordered: ☐ Yes ☐ No ☐ Unknown

Cause of Death:

Circumstances Surrounding Death:

DIAGNOSTIC INFORMATION

DD/ID and Personality Disorders:

Medical Conditions:

Psychiatric Dx:

MEDICATIONS (Use a separate sheet if necessary)

Medication Name	Dosage	Frequency

Please attach supporting documentation
Complete this form and fax to 651-797-1950