

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:

- | | |
|--|--|
| <input type="checkbox"/> African | <input type="checkbox"/> Choose Not to Respond |
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic or Latino |
| <input type="checkbox"/> American Indian or Native Alaskan | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Pacific Islander or Native Hawaiian |
| <input type="checkbox"/> Caucasian or White | |

Legal Representative (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Health Care Agent | <input type="checkbox"/> Private Conservator |
| <input type="checkbox"/> Health Care Directive | <input type="checkbox"/> Private Guardian |
| <input type="checkbox"/> None | <input type="checkbox"/> Public Guardian |
| <input type="checkbox"/> Nonparent/Relative | <input type="checkbox"/> Representative Payee |
| <input type="checkbox"/> Parent | <input type="checkbox"/> Substitute Decision Maker (Commitment Statute 253B.092) |
| <input type="checkbox"/> Power of Attorney | <input type="checkbox"/> Tribal Custody |
| <input type="checkbox"/> Power of Attorney for Health Care Agent | |

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

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

Client Category (check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Developmental/Intellectual Disabilities | <input type="checkbox"/> Mentally Ill and Dangerous |
| <input type="checkbox"/> Chemical Dependency/Substance Use Disorder | <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> Other |
| | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> 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):

- | | |
|--|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Medical Resources Health Care Provider |
| <input type="checkbox"/> Adult or Child Protection or CEP | <input type="checkbox"/> Office of Health Facility Complaints (OHFC) |
| <input type="checkbox"/> Attorney Legal | <input type="checkbox"/> Advocacy/Ombudsman Agency |
| <input type="checkbox"/> County Agency | <input type="checkbox"/> Other – describe _____ |
| <input type="checkbox"/> Facility or Program or Agency Staff | <input type="checkbox"/> Other Advocacy or Ombudsman Agency |
| <input type="checkbox"/> Guardian or Legal Representative | <input type="checkbox"/> Private Agency |
| <input type="checkbox"/> Hospital Review Board | <input type="checkbox"/> State Agency |
| <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Treatment Team |
| <input type="checkbox"/> Licensing Agency | |

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):

- | | |
|--|--|
| <input type="checkbox"/> Accident | <input type="checkbox"/> Natural |
| <input type="checkbox"/> Could not be determined | <input type="checkbox"/> Pending investigation |
| <input type="checkbox"/> Homicide | <input type="checkbox"/> Suicide |

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

Hospice Care: Yes No Autopsy ordered: Yes No Unknown

Limited Treatment: Yes No

Cause of Death:

