Washtenaw County Community Mental Health Report of Death

Date of Report: _____

Client Name:_____ **Case No.**_____ **DOB** _____

Sex: _____ **Race:** _____ **Date and Time of Death** _____

Place of Death _____

Expected Death D **Unexpected Death** D
Critically Ill D **Seriously Ill** D **Chronically Ill** D **No Illness Known** D
(*Check expected or unexpected and illness classification. Definitions in Report and Review of Deaths guideline.)*

Tentative Cause of Death:_____

Date of last discharge: ***(From psychiatric hospital, medical hospital, nursing home etc.)***_____

Date last seen by CMH psychiatry_____ **CSM**_____ **R.N.**_____ **other prof.**_____

Diagnosis:
Psychiatric:_____

Developmental:_____

Medical: _____

Special diet? Yes D **No** D **Type/Reason for diet:**_____

Medications: (*Dose, route, and time administered, if known)*

Last 30 days: _____
_____
_____

Last 24 hours:
_____
_____
_____

Last blood level of lithuim with date: _____

Blood levels of antieleptic medications during the last six months with dates:

Laboratory tests, EKGS, and X-Rays supporting medical diagnoses:

Relevant past medical history supporing medical diagnoses:

Relevant and/or recent medical and surgical treatment:

Recent changes in medical status:

Any unusual circumstances surrounding death: ***(Was the client being physically managed?***
(If accidental death includes the type of accident and how it occurred. If suicide, include if history of previous attempts known, indication for precautions, precautionary measures taken, and method used by the client.)

Summary of Medical Condition and treatment immediately preceding death (*Including any life support measures taken. If transferred to a general hospital, include date and time.)*

Complete form as completely as possible. Attach additional sheets if needed.

Attach a copy of the last physicians review form if client has been seen by CMH psychiatrist.

Submit completed form to CMH Directors Office within 24 hours of notification of death.

Date **Date**

Signature and title of staff completing form **Assigned nurse's signature (if applicable)**

Date

CMH Supervisor signature and title

Upload to Admissions/Transfer/Discharges

Updated 5/2017