ALABAMA DEPARTMENT OF MENTAL HEALTH
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

REGIONAL COMMUNITY SERVICES
COMPREHENSIVE MORTALITY REVIEW

DEMOGRAPHIC DATA

Fname: _____ Lname: _____

Site Address: _____

Residential Opr: _____ 310: _____

Contact Relationship/Agency: _____ Contact Phone: _____

Prog/Loc. Opr.: _____

Date of Birth: _____ Age at Death: _____ Cause: _____

HEALTH INFORMATION—Only needed if death was the result of long term medical condition or medical emergency

Health History for the Past Five Years:

Medications at Time of Death:

Medication Name	Dosage	Frequency

Treatment History Related to Condition or Medical Emergency (include name of physician):

CIRCUMSTANCES OF DEATH

Summary—Discuss events immediately prior, response to emergency, medical treatment received, autopsy findings if applicable:

RECOMMENDATIONS/QUALTIY ENHANCEMENT ACTIONS

_____ _____
Signature of Person Completing Report Date

_____ _____
Signature of Executive Director or designee Date

*****The Comprehensive Mortality Review Report should be attached to the original "Death" GER report in Therap no later than 15 working days of the incident.**