

**ALABAMA DEPARTMENT OF MENTAL HEALTH  
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES**

**REGIONAL COMMUNITY SERVICES  
COMPREHENSIVE MORTALITY REVIEW**

**DEMOGRAPHIC DATA**

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

Site Address: \_\_\_\_\_

Residential Opr: \_\_\_\_\_ 310: \_\_\_\_\_

Contact Relationship/Agency: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

Prog/Loc. Opr.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Death: \_\_\_\_\_ Age at Death: \_\_\_\_\_

Place of Death: \_\_\_\_\_

Cause(s) of Death: \_\_\_\_\_

**HEALTH INFORMATION**

**Description of course of illness (past and present) and cause of the death** in sufficient detail to indicate circumstances of death, including treatment, medications, diagnostic testing, etc. Give findings of diagnostic exams. Insert pages in this section as required.

History and Physical present?	Yes	No
Date of most recent History and Physical:	_____	
Timeliness of Treatment?	Yes	No
Discharge summary from Attending M.D.		

Community Hospital	Yes	No
Autopsy	Yes	No
Toxicology	Yes	No
Death Certificate Available	Yes	No

**Complete if Death Occurred in LOCAL COMMUNITY HOSPITALIZATIONS ONLY:**

Type of Admission:	Routine	Emergent	Other
Method of transportation appropriate to patient condition:	Critical	Stable	Unknown
Prognosis on admission to local hospital:	Poor	Good	Unknown
Were diagnosis procedures appropriate and timely?		Yes	No
Was treatment appropriate to diagnosis and institute timely?		Yes	No
Prognosis with treatment:	Poor	Good	Unknown
Any complications adversely affecting outcome? (Please describe briefly)		Yes	No

Complications related to surgical procedures? (Please describe) Yes                  No

Prognosis following surgical procedure: Poor Good Unknown

Patient compliant with treatment/medications: Yes No N/A

Discussion with patient or patient's family regarding patient diagnosis: Yes No N/A

DNR Order: Yes No Date: \_\_\_\_\_

Advance Directive/Living Will/DNR/  
Advanced Directive discussed in PCP: Yes No Date: \_\_\_\_\_

**REVIEW OF EMERGENCY MEDICAL CARE:**

Was death related to a medical emergency? Yes                  No

Response to medical emergency:



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**

**Attachments (Please check):**

1. Medical Record
  2. Narrative Summary
  3. Death Certificate
  4. Autopsy Report
  5. Other Documents as appropriate (list)
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\_\_\_\_\_  
Signature of Person Completing Report

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Executive Director or Designee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of ADMH/DD Regional Nurse

\_\_\_\_\_  
Date

**ALL INFORMATION CONTAINED IN THIS REPORT IS EXEMPT AND TO BE CONSIDERED FOR REVIEW/VIEWING ON A NEED TO KNOW BASIS ONLY.**

**\*\*\*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.**