

**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 EMERGENY 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

Signature of ADMH/DD Community Services Director

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.**

Effective: May 1, 2004
Revised: October 20, 2020