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? ☐ Yes ☐ No
(Please describe briefly)

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:

Date Family Notified: _____

CPR used ☐ Yes ☐ No ☐ N/A

Problems encountered during medical emergency, e.g., equipment, communications, transportation. ☐ Yes ☐ No ☐ NA

Describe briefly:

Documentation in medical record reviewed by Mortality Review Committee and found to be within acceptable limits. If no, please describe. ☐ Yes ☐ No ☐ N/A

Medications at Time of Death:

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)

_____

_____

_____ _____

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 REVIEIW/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.**