

# NOTICE OF DEATH FORM

**Within 4 hours** of the discovery of a death that is or may be a Suspicious, Unexpected, or Unexplained Death, the entity responsible for reporting the death shall report it to the DMRS Investigator. Also, **within 4 hours** of the discovery of any death, the primary provider must notify the DMRS Regional Director or, if applicable, the DMRS Assistant Commissioner of Facility Services by telephone. A completed **Notice of Death Form** must be sent **within 1 business day** after discovery of the death. If a waiver provider or private ICF/MR, send it to the DMRS Regional Director. If a developmental center, send it to the Assistant Commissioner of Facility Services and to the Deputy Commissioner.

**East DMRS Regional Director**

Phone # (865) 588-0508

Fax # (865) 594-5180

Crisis Pager 1-800-225-9302

**Middle DMRS Regional Director**

Phone # (615) 231-5436

Fax # (615) 231-5150

Crisis Pager (615) 963-1700

**West DMRS Regional Director**

Phone # (901) 745-7361

Fax # (901) 745-7379

Crisis Pager 1-866-925-4204

**SERVICE RECIPIENT INFORMATION****DMRS REGION** [ ] East [ ] Middle [ ] West**NAME** \_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_**SOCIAL SECURITY NO.** \_\_\_\_\_ **AGE AT DEATH** \_\_\_\_\_**RACE** [ ] White [ ] Black [ ] Hispanic [ ] Other \_\_\_\_\_ **SEX** [ ] Male [ ] Female**CLASS MEMBER STATUS** [ ] Settlement Agreement [ ] Remedial Order [ ] Not applicable**FUNDING STATUS** [ ] "Statewide" Waiver [ ] "Self-Determination" Waiver [ ] Private ICF/MR  
[ ] "Arlington" Waiver [ ] State-Funded [ ] Developmental Center**RESIDENCE** [ ] Lived with family [ ] Supportive Living [ ] Private ICF/MR  
[ ] Lived in Own Home with Support [ ] Residential Habilitation [ ] Developmental Center  
[ ] Lived Independently [ ] Medical Residential Services [ ] Nursing Facility  
[ ] Family Model Residential Services [ ] Other (explain) \_\_\_\_\_**DID THE SERVICE RECIPIENT MOVE IN THE PAST 6 MONTHS?** [ ] No [ ] Yes (specify date: \_\_\_\_\_)**DATE OF DEATH** \_\_\_\_\_ **DATE REPORTED** \_\_\_\_\_ **TIME REPORTED** \_\_\_\_\_ AM / PM**PLACE OF DEATH** [ ] Home [ ] Psychiatric Facility  
[ ] Hospital [ ] Other \_\_\_\_\_**DETAILS OF DEATH** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**1. AUTOPSY REQUESTED?** [ ] No [ ] Yes If so, by whom \_\_\_\_\_  
**2. MEDICAL EXAMINER CONTACTED?** [ ] No [ ] Yes If so, by whom \_\_\_\_\_  
**3. CORONER CONTACTED?** [ ] No [ ] Yes If so, by whom \_\_\_\_\_  
**4. INCIDENT FORM SUBMITTED?** [ ] No [ ] Yes**INDICATE WHO HAS BEEN NOTIFIED** [ ] ISC/Case Manager [ ] Legal Representative [ ] Family  
[ ] DMRS Investigator [ ] Police**NAME OF PRIMARY CARE PROVIDER** \_\_\_\_\_ **PHONE NO.** \_\_\_\_\_**TYPE OF CASE MANAGER** [ ] ISC [ ] State Case Manager [ ] QMRP**NAME OF CASE MANAGER** \_\_\_\_\_ **PHONE NO.** \_\_\_\_\_**NAME OF ISC AGENCY (if applicable)** \_\_\_\_\_ **PHONE NO.** \_\_\_\_\_

# GENERAL HEALTHCARE INFORMATION

NAME OF SERVICE RECIPIENT \_\_\_\_\_

AMBULATION:       Ambulatory  
                       Non-ambulatory

COMMUNICATION     Verbal  
                           Non-verbal

NUTRITION     Eats independently  
                   Eats with assistance  
                   Tube-fed

WEIGHT IS     Normal Weight  
                   Overweight  
                   Underweight

WEIGHT \_\_\_\_\_

HEIGHT \_\_\_\_\_

PHYSICAL STATUS REVIEW (if applicable)    DATE OF LAST PSR \_\_\_\_\_    PSR LEVEL \_\_\_\_\_

## MEDICATIONS

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MR LEVEL     Mild     Moderate     Severe     Profound     Unknown/Unspecified

Etiology (if known) \_\_\_\_\_

## BEHAVIORAL/PSYCHIATRIC DIAGNOSES

_____	_____
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## GENERAL MEDICAL DIAGNOSES

_____	_____
_____	_____
_____	_____

## HOSPITALIZATIONS AND PROCEDURES IN PAST 12 MONTHS

<u>Reason for Hospitalization or Procedure</u>	<u>Treatment Location</u>	<u>Date</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____	_____
Name of Provider, Private ICF/MR, or DMRS Developmental Center	Phone Number
_____	_____
Print Name of Person Completing This Form	Title
_____	_____
Signature	Date
_____	_____