

# PROVIDER'S DEATH REVIEW FORM

A Provider's Death Review shall be completed within five (5) business days of the death of a service recipient who is

1. Receiving a residential service through an HCBS waiver program or other DMRS community program;
2. A resident of a DMRS developmental center; or
3. A resident of a private ICF/MR when such residence is state-funded or funded by TennCare/Medicaid.

Providers and private ICFs/MR shall submit the form to the DMRS Regional Director. DMRS developmental centers shall submit the form to the DMRS Assistant Commissioner of Facility Services and to the DMRS Deputy Commissioner.

## SERVICE RECIPIENT INFORMATION

Name (last, first, middle) \_\_\_\_\_ SSN \_\_\_\_\_

Home Address \_\_\_\_\_

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

Name of Service Provider \_\_\_\_\_

Name of Director of Provider Agency, Administrator of Private ICF/MR, or Chief Officer of DMRS Developmental Center: \_\_\_\_\_

**1. Please circle "Yes" or "No".**

- a. **YES NO** Service recipient was discharged from a developmental center within the past 12 months.
- b. **YES NO** Service recipient resided in the current community placement less than 12 months.
- c. **YES NO** Service recipient's family or conservator was involved in care/treatment and visited often.

**2. Briefly describe the service recipient's functional independence in daily living.**

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**3. Briefly describe the service recipient's need for special custodial care and supervision.**

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**4. Briefly describe the service recipient's physical limitations.**

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5. List the service recipient's medical diagnoses or conditions.

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6. Please indicate whether "End of Life" issues were discussed at the most recent annual Individual Support Plan Meeting, and describe any "End of Life" plans.

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**CIRCUMSTANCES SURROUNDING THE DEATH**

1. Briefly describe the situation or circumstances surrounding the service recipient's death:

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2. Specify the location where service recipient died or was found dead: \_\_\_\_\_

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3. Please circle "Yes" or "No".

- a.    YES    NO    Service recipient's cause of death was known.
- b.    YES    NO    Service recipient died in a hospital. If "Yes", specify hospital and date of admission:  
\_\_\_\_\_
- c.    YES    NO    An autopsy was done.
- d.    YES    NO    Family or conservator guardian declined to have an autopsy done.
- e.    YES    NO    Service recipient received emergency medical procedures (e.g., CPR, Heimlich)  
immediately prior to death. If "Yes", specify types: \_\_\_\_\_  
\_\_\_\_\_
- f.    YES    NO    Service recipient's death was unexpected. If Yes, specify why: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CIRCUMSTANCES ASSOCIATED IN TIME WITH THE DEATH:** "Associated" as used here does not imply that the circumstance "caused" the death, but rather that the circumstance was associated in time with the death. Please circle "Yes" or "No". For any "Yes" response, provide an explanation in the space provided.

1.    **YES**    **NO**    An actual or suspected seizure
2.    **YES**    **NO**    A choking incident or aspiration of food/liquids, vomit, or foreign bodies
3.    **YES**    **NO**    A fall
4.    **YES**    **NO**    An environmental problem or hazard
5.    **YES**    **NO**    Self-injurious behavior (e.g., PICA, suicidal behavior)
6.    **YES**    **NO**    A behavioral incident involving the service recipient
7.    **YES**    **NO**    A lapse in staff supervision
8.    **YES**    **NO**    A violent act by a staff person
9.    **YES**    **NO**    A violent act by any other individual
10.   **YES**    **NO**    A "Do Not Resuscitate" order and/or *Physician Scope of Treatment* (POST FORM)

Provide a brief explanation for any "Yes" response to Items #1 to 10 above, attaching additional sheets if needed:

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**FOLLOW-UP**

1.    **Please describe any Issues requiring further review or follow-up:** \_\_\_\_\_  
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<hr/> <b>Print Name of Person Completing This Form</b>	<hr/> <b>Title</b>
<hr/> <b>Signature</b>	<hr/> <b>Date</b>