**State of Delaware**

**Division of Substance Abuse and Mental Health**

***CONFIDENTIAL*** **DSAMH Death Report Form** ***CONFIDENTIAL***

**This form is used to report deaths involving any/all persons receiving state funded mental health and/or substance abuse services. Pursuant to 42 CFR 482.13(f)(7); 29 Del. C., § 4706; and DHSS PM 46, all deaths related to the use of seclusion or restraint, accidents, homicides, suicides or violence (including those suspected as consumer abuse, neglect, and mistreatment) must be reported. This is a confidential quality assurance document and is peer protected pursuant to 24 Del. C., § 1768. Confidentiality of consumer information is protected under Federal Regulations (42 U.S.C. 4582 and 21 U.S.C. 1175) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (45 C.F.R. Pts. 160 and 164). Please provide an explanation for any requested information that is unavailable. If additional space is needed, attach separate sheets, referencing the part of the form to which the information pertains. Additional information that is considered relevant, such as client assessments and discharge summaries may be included. Do not file this review report in the consumer’s service record. Please keep a copy of the report for your records. Send or fax form to:**

**Director of Community Mental Health Services, Main Administration Bldg., 19 01 N. DuPont Hwy., New Castle DE 19720. Fax: 302-255-4499.**

**MODALITY:  MENTAL HEALTH CONDITION  SUBSTANCE USE CONDITION**

**SEX:  MALE  FEMALE**

|  |  |  |  |
| --- | --- | --- | --- |
| **CONSUMER INFORMATION:** | | | |
| **NAME OF CONSUMER**  Click or tap here to enter text. | | | **RECORD # OF CONSUMER**  Click or tap here to enter text. |
| **DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_\_\_**  **DATE OF DEATH: \_\_\_/\_\_\_/\_\_\_\_\_**    **ADMISSION DATE: \_\_\_/\_\_\_/\_\_\_\_\_** | | | **LAST KNOWN ADDRESS**  Click or tap here to enter text. |
| **REPORTING INFORMATION:** | | | |
| **NAME OF REPORTING FACILITY**  Click or tap here to enter text. | | | **ADDRESS**  Click or tap here to enter text. |
| **NAME OF THERAPIST/CASE MANAGER**  Click or tap here to enter text. | | | **NAME OF IMMEDIATE SUPERVISOR**  Click or tap here to enter text. |
| **NAME OF PERSON PREPARING REPORT**  Click or tap here to enter text. | | | **DATE/TIME REPORT PREPARED**  Click or tap here to enter text. |
| **MOST RECENT CONSUMER CONTACT**  **DATE: \_\_\_/\_\_\_/\_\_\_\_\_**  **METHOD:  FACE TO FACE**  **PHONE**  **CORRESPONDENCE** | | | **RACE/ETHNICITY ( *check all that apply*)**  **1 *WHITE/ANGLO***  **2 *BLACK/AFRICAN AMERICAN***  **3 *ASIA/PACIFIC ISLANDER***  **4 *NATIVE AMERICAN***  **5 *HISPANIC/LATINO***  **6 *OTHER* (*specify*) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **CAUSE OF DEATH: (*check all that apply*)** | | | **CIRCUMSTANCES/LOCATION (*attach reporting documents*)** |
| **TERMINAL ILLNESS (*specify*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)**  **ACCIDENT**  **NATURAL CAUSES  DRUG OVERDOSE**  **SUICIDE  HOMICIDE/VIOLENCE**  **EXPECTED or  UNEXPECTED *explain*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **COMPLICATION OF CHRONIC/ACUTE MEDICAL**  **CONDITION**  **WITHIN 7 DAYS OF A RESTRICTIVE INTERVENTION**  **UNKNOWN CAUSE** | | | Click or tap here to enter text. |
| **PRIMARY CLINICAL / MEDICAL DIAGNOSES AT TIME OF DEATH:** | | | |
| **AXIS I:**  Click or tap here to enter text. | | | **AXIS II:**  Click or tap here to enter text. |
| **AXIS III:**  Click or tap here to enter text. | | | **AXIS IV:**  Click or tap here to enter text. |
| **MOST RECENT GAF:**  Click or tap here to enter text. | | | **GAF DATE :**  Click or tap to enter a date. |
| **PSYCHOTROPIC/MEDICAL MEDICATIONS (*please list all*)**  Click or tap here to enter text. | | | **TREATMENT RECEIVED PRIOR TO DEATH:**  **COUNSELING/THERAPY**  **SMOKING CESSATION**  **GROUPS**  **MEDICATION MANAGEMENT**  **CASE MANAGEMENT**  **REHABILITATION (*specify)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **PHARMACOLOGICAL AGENTS ADJUNCT TO SUSTANCE USE TREATMENT (*please list: naltrexone, methadone, etc.)***  Click or tap here to enter text. | | | **PCP NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **DATE OF LAST 2 MEDICAL EXAMS:**  **\_\_\_/\_\_\_/\_\_\_\_\_ AND \_\_\_/\_\_\_/\_\_\_\_\_**  **ACTIVE SMOKER QUANTITY PER DAY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **COMPLIANCE WITH TREATMENT:** | | | **POST MORTEM INVESTIGATIONS:**  **POLICE DATE CONTACTED:** Click or tap to enter a date.  **MEDICAL DATE CONTACTED:** Click or tap to enter a date.  **EXAMINER**  **DHSS PM 46 DATE INITIATED:** Click or tap to enter a date. |
| **MEDICAL:** | **PSYCHIATRIC:** | **SUBSTANCE USE:** |
| **COOPERATIVE** | **COOPERATIVE** | **COOPERATIVE** |
| **SPORADIC** | **SPORADIC** | **SPORADIC** |
| **QUESTIONABLE** | **QUESTIONABLE** | **QUESTIONABLE** |
| **UNCOOPERATIVE** | **UNCOOPERATIVE** | **UNCOOPERATIVE** |
| **NAME OF PERSON COMPLETING REPORT:**  Click or tap here to enter text. | | | **NAME OF AGENCY SUPERVISOR:**  Click or tap here to enter text. |