MACOMB COUNTY OFFICE OF SUBSTANCE ABUSE
REPORT OF DEATH FORM

Provider Name: _____ **Primary Therapist Name**: _____

Consumer Name : _____ **DOB:** _____

Case #_____ **SSN #:**_____

Weight: _____ **Height:** _____ **Marital Status: S / M / D** **Gender: M / F**

Level of Treatment: ☐ OP ☐ OMT ☐ IOP ☐ Detox ☐ Residential **Admission Date**: _____

Total Number of Visits: _____ **Last Treatment Contact Date :** _____

Status of Case at Time of Death: ☐ Open ☐ Closed; If Closed, Date of Discharge: _____

Clinical Progress: Prior to the report of death, consumer was : ☐ Abstinent/Compliant with Treatment

☐ Abstinent/Non-compliant ☐ Relapsed/Compliant ☐ Relapsed/Non-compliant ☐ Unknown

Clinically/behaviorally how was consumer doing just prior to report of death, or if discharged, just prior to discharge?

☐ Greatly Improved ☐ Moderately Improved ☐ Slightly Improved ☐ Unchanged

☐ Regressed ☐ Unknown Explain:_____

Most Recent DSM-IV Diagnosis:

Axis I (SA) _____
Axis I (SA) _____
Axis I (MH)_____
Axis II _____
Axis III _____
Axis IV ☐ Primary Supports ☐ Social Environment ☐ Educational
☐ Occupational ☐ Housing ☐ Economic
☐ Health Care Access ☐ Legal ☐ Other _____
Axis V Most Recent GAF _____ Highest GAF Last Year _____

Medical: Primary Care Physician (PCP):_____

Any hospitalizations: Y / N (if yes, when & why)_____

☐ Nicotine use ☐ Diabetes ☐ Hypertension

Medications: Include all current prescribed or OTC medications used for medical or psychiatric treatment.

_____
(Medication) (Rx/OTC) (Name Prescribing MD) (Clinic or Private/HMO MD) (Date Most recent Med Rev.)

_____
(Medication) (Rx/OTC) (Name Prescribing MD) (Clinic or Private/HMO MD) (Date Most recent Med Rev.)

Use reverse side for additional medications:

Date of Death: _____ **Age @ Time of Death:**_____

How and when (date) was program notified of death? _____

Place and Circumstance of Death (Include whether or not substance use was involved):_____
(Use reverse side for additional information)

Preliminary Cause of Death:

☐ Suicide ☐ Homicide ☐ Accident ☐ Overdose ☐ Natural Causes/Preexisting Illness

☐ Undetermined/Pending

☐ Other (Explain/Clarify): _____

Additional Comments/Relevant Information regarding Consumer Death:_____
(Use reverse side for additional comments/information):

Secondary Cause of Death:

☐ Suicide ☐ Homicide ☐ Accident ☐ Overdose ☐ Natural Causes/Preexisting Illness

☐ Undetermined/Pending ☐ Other (Explain/Clarify): _____

Additional Comments/Relevant Information regarding Consumer Death:_____
(Use reverse side for additional comments/information):

Actions taken by Program after Report of Death: (Check all that Apply)

☐ Incident Review ☐ Mortality Review

☐ Sentinel Event Review ☐ Root Cause Analysis ☐ Other: _____ (Describe)

☐ None: (If none explain) _____

Actions Taken *as a Result of the Investigation* of Consumer Death:

_____

(**Supervisory Staff Completing Report**) (**Date**)

Additional Comments: