MACOMB COUNTY COMMUNITY MENTAL HEALTH
PROVIDER MORTALITY REVIEW

(To be completed by clinically responsible Provider Mortality Review Team)

VENDOR ORGANIZATION NAME: _____

Vendor #_____

Provider #_____

PROVIDER NAME: _____

Consumer Information:

Consumer: _____ Clinical Record # _____

Documents Reviewed: [List all documents reviewed, i.e.: clinical record, autopsy report]

_____

_____

_____

Summary of Findings: _____

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_____

Identified Areas for Improvement: _____

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_____

Plan of Action / Recommendations: _____

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_____

Review Team Members: _____

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Send to: MCCMH Office of the Chief Medical Officer
19800 Hall Road
Clinton Township, MI 48038