Incident Management Report of Death

Member's Name:		**TABS ID:**	
CM Name:		**CM Phone #:**	
Date Form Was Prepared:		**Date of Death:**	

SECTION ONE:			
Member's height:		Member's weight:	
Select the primary contributing factor to death		Choose an item	

SECTION TWO:
List the name and address of all services the member was receiving (day/ community habilitation, SEMP, etc.). **If none, indicate "None."**

List all mental disability and developmental diagnoses (including substance abuse diagnoses):			
ICD Code		Diagnosis	
ICD Code		Diagnosis	
ICD Code		Diagnosis	
ICD Code		Diagnosis	
ICD Code		Diagnosis	

Date of last ER visit for psychiatric or substance abuse reasons:				None ☐
From:		To:		
Date of last hospitalization for psychiatric or substance abuse				**None ☐**
From:		To:		

List all physical illnesses/conditions diagnosed prior to death:			
ICD Code		Diagnosis	
ICD Code		Diagnosis	
ICD Code		Diagnosis	
ICD Code		Diagnosis	
ICD Code		Diagnosis	
ICD Code		Diagnosis	

Date of last ER visit for physical illnesses/conditions:				None ☐
From:		To:		
Date of last hospitalization for physical reasons:				**None ☐**
From:		To:		

List all medications prescribed at the time of death:			
Medication	Dose (in mg.)	Frequency	How administered
			Choose an item
			Choose an item
			Choose an item
			Choose an item
			Choose an item
			Choose an item
			Choose an item
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			Choose an item
			Choose an item

SECTION THREE:			
Pronounced Time of Death:		Actual Time of Death:	
Location where the member passed away:		Choose an item	
Location Street			
Location City			
Location State			
Location Zip Code			

Cause of Death: You can obtain from the death certificate, the family, the hospital, or medical staff	
Immediate cause of death:	
Due to or because of:	
Due to or because of:	

1. Manner of death:	Choose an item
2. Was an autopsy completed:	Choose an item
3. Name of physician who pronounced the member deceased:	
4. Phone # of physician:	

Within 24hrs of death, was the member… (choose all that apply)	
On DNR/DNI status ☐	Given stat/PRN medication for behavioral or psychiatric reasons ☐
None ☐	**Unknown ☐**
If unknown, please indicate why it is unknown?	

Is there any indication that this death may… (choose all that apply)	
Have resulted from an accident ☐	Have resulted from a homicide ☐
Have resulted from a suicide ☐	Have resulted from a med error ☐
Have resulted from a med/drug overdose ☐	Have resulted from the use of a controlled substance or alcohol ☐
Have resulted from attempted use of restraint ☐	Have resulted from the attempted use of seclusion/time-out ☐
Be an unexplained death ☐	Be an unexpected death ☐
None ☐	**Unknown ☐**
If unknown, please indicate why it is unknown?	

SECTION FOUR:
Narrative summary: Describe the member's psychiatric, behavioral, and medical status within 90 days prior to their death.

Enter dates of routine medical follow-up within the last 90 days prior to death:			
Primary care visit		☐ None	☐ Unknown
Cardiologist		☐ None	☐ Unknown
Gastroenterologist		☐ None	☐ Unknown
Urologist		☐ None	☐ Unknown
Gynecologist		☐ None	☐ Unknown
Neurologist		☐ None	☐ Unknown
Orthopedist		☐ None	☐ Unknown
Pulmonologist		☐ None	☐ Unknown
Other		☐ None	☐ Unknown
If other, indicate type of provider			
If unknown, indicate why:			

Acute medical issues within 90 days prior to death:			
Choking	☐ Yes	☐ No	☐ Unknown
Fall	☐ Yes	☐ No	☐ Unknown
Seizure	☐ Yes	☐ No	☐ Unknown
Weight loss:	☐ Yes	☐ No	☐ Unknown
Weight gain:	☐ Yes	☐ No	☐ Unknown
Change in bowel habits	☐ Yes	☐ No	☐ Unknown
Change in bladder habits	☐ Yes	☐ No	☐ Unknown
Change in ambulation	☐ Yes	☐ No	☐ Unknown
Change in food intake	☐ Yes	☐ No	☐ Unknown
Change in medication	☐ Yes	☐ No	☐ Unknown
Change in fluid intake	☐ Yes	☐ No	☐ Unknown
Other	☐ Yes	☐ No	☐ Unknown
If other, indicate type of acute medical issue:			
If unknown, indicate why:			

List the safeguards for the member at home, in the community, and any safeguards related to meals/dining:

Diet prior to death:	Food	Choose an item	Fluid	Choose an item
Were all components of the eating plan followed at the time of death?				Choose an item

Indicate significant changes in the 90 days prior to death that impacted the member: *Check all boxes that apply.			
Changes in service providers:			
☐ Residence	☐ Program	☐ Care Manager	
☐ Transportation	☐ Medical Provider	☐ Unknown	☐ None

Changes in treatment regimen:			
☐ Medication	☐ Diet	☐ Supervision	
☐ Behavior Plan	☐ Treatment Plan	☐ Unknown	☐ None

Changes in Level of Functioning:			
☐ Decline in physical health	☐ Required increased monitoring/supervision	☐ Required increased assistance with ADL's	
☐ Required increased monitoring/supervision	☐ Comfort care	☐ Placed on hospice	
☐ Comfort care	☐ Required increased monitoring/supervision	☐ Unknown	☐ None

Describe the circumstances leading up to and including the member's death:

Submitted to IM by:		Date submitted:	