REQUEST FOR INFORMATION MORTALITY REVIEW

State Form 53266 (R / 3-08) / QA 2000

Family and Social Services Administration
Division of Aging
Mortality Review Process

This document contains confidential medical information and is not subject to disclosure as a public record.

(*Type or print all information. When attaching additional sheets, clearly indicate which answer is being continued.*)

To: Mortality Review Process
Division of Aging
402 West Washington Street
IGCS, Room W454, MS-21
P.O. Box 7083
Indianapolis, IN 46207-7083
Fax: Brenda Hogan (317) 232-7867
Telephone: Brenda Hogan (317) 232-7132

From:

Agency
Address (*number and street*)
City, state, ZIP code
Name of contact person (*name and title*)
Telephone number ( )

PARTICIPANT INFORMATION

Name of deceased	Date of death (*month, day, year*)	Date of birth (*month, day, year*)
Gender ☐ Male ☐ Female	County where death occurred	Race
Address of deceased (*number and street, city, state, and ZIP code*)		

PROGRAM INFORMATION

Service type (*check the appropriate service type*):
☐ A&D Waiver ☐ Traumatic Brain Injury Waiver ☐ CHOICE ☐ Other: ______

Was the deceased a resident of a nursing facility in the previous ninety (90) days prior to death?
☐ Yes ☐ No

If Yes, name of facility		Date of discharge (*month, day, year*)
Address of facility (*number and street, city, state, and ZIP code*)		
County of facility	Name of contact person	Telephone number ( )

REPORTING CONTACT VERIFICATION

Date of this report (*month, day, year*)

CONTACT	DATE	TIME	NAME OF PERSON CONTACTED	HOW NOTIFIED	NOTIFIED BY WHOM
APS (*required for age 18 and over*)					
DCS (*required for under age 18*)					

Contact information for individual(s).

Name of legal guardian (*if applicable*)	Relationship	Telephone number ( )
Address (*number and street, city, state, and ZIP code*)		
Name of case manager	Case manager's agency	Telephone number ( )
Address of case manager (*number and street, city, state, and ZIP code*)		
Name of APS / DCS contacted	APS / DCS county	Telephone number ( )
Address of APS / DCS (*number and street, city, state, and ZIP code*)		

INFORMATION REGARDING DEATH

1) Date of death (*month, day, year*)

2) Day of death

3) Time of death ☐ AM ☐ PM

4) Address where death occurred (*number and street, city, state, and ZIP code*)

5) Type of setting where death occurred

6) Name of setting where death occurred (*if applicable*)

7) Primary cause of death

8) Secondary cause of death

9) Was death result of suspected or alleged abuse or neglect? ☐ Yes ☐ No

Was death result of suspected or alleged suicide or homicide? ☐ Yes ☐ No

Was death result of trauma or accident? ☐ Yes ☐ No

10) Was a terminal illness diagnosed? ☐ Yes ☐ No ☐ Unknown

If Yes, were hospice services provided? ☐ Yes ☐ No

11) Identify terminal illness

12) Name of physician attending at time of death (*if applicable*)

13) Telephone number of attending physician
( )

14) Address of attending physician (*number and street, city, state, and ZIP code*)

15) Advance Directive / DNR status ☐ Yes ☐ No ☐ Unknown

16) Postmortem reports: Was an autopsy completed? ☐ Yes ☐ No

17) If yes, provide contact information for autopsy report.

18) Name of primary physician

19) Telephone number of primary physician
( )

20) Address of primary physician (*number and street, city, state, and ZIP code*)

21) Date of client's last medical appointment with primary physician (*month, day, year*)

22) Have there been any incident reports, per DA reporting requirements, of abuse, neglect or injuries sustained by deceased (*for 12 months prior to death*)?
☐ Yes ☐ No

23) If Yes, indicate the type of report and the date of report and attach any copies of relevant information relating to incidents that occurred prior to the individual's death.

TYPE OF REPORT	DATE REPORTED (*month, day, year*)

HOSPITALIZATION INFORMATION

24) Was the client hospitalized in the six (6) months preceding time of death?
☐ Yes ☐ No

If Yes, list name of hospital date(s) of admission(s) / date(s) discharged / reason(s) for hospitalization.

Name of hospital

Date of admission (*month, day, year*)

Date of discharge (*month, day, year*)

Address of hospital (*number and street, city, state, and ZIP code*)

Reason for hospitalization

Physician's orders upon discharge

HOSPITALIZATION INFORMATION *(continued)*

Name of hospital	Date of admission (*month, day, year*)	Date of discharge (*month, day, year*)
Address of hospital (*number and street, city, state, and ZIP code*)		
Reason for hospitalization		
Physician's orders upon discharge		
Name of hospital	Date of admission (*month, day, year*)	Date of discharge (*month, day, year*)
Address of hospital (*number and street, city, state, and ZIP code*)		
Reason for hospitalization		
Physician's orders upon discharge		
Name of hospital	Date of admission (*month, day, year*)	Date of discharge (*month, day, year*)
Address of hospital (*number and street, city, state, and ZIP code*)		
Reason for hospitalization		
Physician's orders upon discharge		

ADDITIONAL INFORMATION

25) Provide copies of the following data for the 30-day period prior to the death from any HCBS provider serving this individual.
(*Submit in chronological order from date of death. If hospitalized prior to death, proved information for the last 30 days of services provided*)

- Staff notes
- Nurses notes
- Staffing schedules up to and including the date of the participant's death

ADDITIONAL INFORMATION (*continued*)

26) Give any additional information that you feel is pertinent to this report. (*use additional sheets, if necessary*)

VERIFICATION OF INFORMATION INCLUDED IN THE REPORT

27) Signature

I hereby verify that the information contained in this report is accurate.

Signature	Date verified (*month, day, year*)
Printed Name and Title	Telephone number ( )

This form is HIPAA compliant per the requirements of 45 CFR § 164.508(c).