

This Review Conducted Under the Indiana Peer Review Statue and is Privileged Information

Date Form Completed:

Client Death Date:

ID :

Name:

Address:

City, State, ZIP

Gender/DOB/Age:

Was this a BPHC _____, Recovery Works _____ or AMHH Client? N/A_____

Were any Perpetrators Involved: Yes___ N___ (If so please describe below.)

Date, Time and Location/Address of Death: (Please include all know information at the time of notification.)

Pending Legal Charges? Yes_____ No___ (If yes, include brief description below)

Was there a need to notify APS/CPS? Yes___ No___

Current Episode Dates:

List Specific Services Provided in this Current Episode of Care:

Specific Type of Last Service, Date and Provider:

Last Evaluation and Management Service and Provider if Applicable:

ICD-10 Diagnosis Codes:

Primary Physical Health Conditions and ICD-10 Code if Known:

Medications (Include non-psychiatric medications if known.)

List any Changes in Types and Dosages of Medications in the last 90 days:

Description of Event/Report from the Providers (Briefly describe only factual information about how provider/location found out about death, and from whom, any information known about the death not reported above and general description of the last contacts with client. Describe any interactions or communications with family or significant others related to event.)

Any Precautions Taken Prior to the Event? (Include if there was a Safety Plan, or other pertinent treatment issues/plans for client safety)

Incident Resolution/Recommendations: (Include if assisting family with arrangements, if there will be a coroner report, if autopsy conducted and if family/others offered additional info or will share reports. This may not be immediately known, but if so, please include.)