RESET

INITIAL AGENCY DEATH REVIEW FORM

An Initial Agency Death Review shall be completed within five (5) business days of the death of a person supported who is
1. Receiving a residential service through an HCBS waiver program or other DIDD community program;
2. A resident of a DIDD ICF/ID; or
3. A resident of a private ICF/ID when such residence is state-funded or funded by TennCare/Medicaid.

Providers and private ICFs/ID shall submit the form to the DIDD Regional Director. DIDD ICF/ID shall submit the form to the DIDD Commissioner or designee.

INFORMATION OF PERSON SUPPORTED

Name (last, first, middle) _____ SSN _____

Home Address _____

Date of Birth _____ _____ _____ Date of Death _____ _____ _____ Age at Death _____

Name of Service Provider _____

Name of Director of Provider Agency, Administrator of Private ICF/ID, or Director of DIDD ICF/ID or Chief Officer: _____

Name(s) of Next of Kin and/or Legal Representative: _____

1. Please circle "Yes" or "No".

a. ☐ **YES** ☐ **NO** Person supported was discharged from a developmental center within the past 12 months.

b. ☐ **YES** ☐ **NO** Person supported resided in the current community placement less than 12 months.

c. ☐ **YES** ☐ **NO** The family or conservator of the person supported was involved in care/treatment and .

2. Briefly describe the functional independence in daily living for the person supported.

3. Briefly describe the need for special custodial care and supervision of the person supported.

4. Briefly describe the physical limitations of the person supported.

5. List the medical diagnoses or conditions of the person supported.

6. Please indicate whether "End of Life" issues were discussed at the most recent annual Individual Support Plan Meeting, and describe any "End of Life" plans.

CIRCUMSTANCES SURROUNDING THE DEATH

1. Briefly describe the situation or circumstances surrounding the death of a person supported:

2. Specify the location where person supported died or was found dead:

_____

3. Please circle "Yes" or "No".

a. ☐ **YES** ☐ **NO** Cause of death of the person supported was known.

b. ☐ **YES** ☐ **NO** Person supported died in a hospital. If "Yes", specify hospital and date of admission:

_____

c. ☐ **YES** ☐ **NO** An autopsy was done.

d. ☐ **YES** ☐ **NO** Family or conservator guardian declined to have an autopsy done.

e. ☐ **YES** ☐ **NO** Person supported received emergency medical procedures (e.g., CPR, Heimlich) immediately prior to death. If "Yes", specify types:

f. ☐ **YES** ☐ **NO** Death of the person supported was unexpected. If Yes, specify why:

CIRCUMSTANCES ASSOCIATED IN TIME WITH THE DEATH: "Associated" as used here does not imply that the circumstance "caused" the death, but rather that the circumstance was associated in time with the death. Please circle "Yes" or "No". For any "Yes" response, provide an explanation in the space provided.

1. ☐ **YES** ☐ **NO** An actual or suspected seizure

2. ☐ **YES** ☐ **NO** A choking incident or aspiration of food/liquids, vomit, or foreign bodies

3. ☐ **YES** ☐ **NO** A fall

4. ☐ **YES** ☐ **NO** An environmental problem or hazard

5. ☐ **YES** ☐ **NO** Self-injurious behavior (e.g., PICA, suicidal behavior)

6. ☐ **YES** ☐ **NO** A behavioral incident involving the service recipient

7. ☐ **YES** ☐ **NO** A lapse in staff supervision

8. ☐ **YES** ☐ **NO** A violent act by a staff person

9. ☐ **YES** ☐ **NO** A violent act by any other individual

10. ☐ **YES** ☐ **NO** A "*Do Not Resuscitate*" order and/or *Physician Scope of Treatment* (POST FORM)

Provide a brief explanation for any "Yes" response to Items #1 to 10 above, attaching additional sheets if needed:

FOLLOW-UP

1. Please describe any Issues requiring further review or follow-up:

_____	_____
Print Name of Person Completing This Form	**Title**
_____	_____
Signature	**Date**