DEPARTMENT OF
INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

NOTICE OF DEATH FORM

Within 4 hours of the discovery of a death that is or may be a Suspicious, Unexpected, or Unexplained Death, the entity responsible for reporting the death shall report it to the DIDD Investigator. Also, **within 4 hours** of the discovery of any death, the primary provider must notify the DIDD Regional Office Administrator of the Day or, if applicable, the DIDD ICF/ID Director or Chief Officer or designee by telephone. A completed **Notice of Death Form** must be sent **within 1 business day** after discovery of the death. If a waiver provider or private ICF/IID, send it to the DIDD Regional Director. If a developmental center, send it to the DIDD Facilities Administrator and to the Deputy Commissioner.

East DIDD Regional Director		**Middle DIDD Regional Director**		**West DIDD Regional Director**	
Phone #	(865) 588-0508	Phone #	(615) 231-5436	Phone #	(901) 745-7361
Fax #	(865) 584-5275	Fax #	(615) 231-5350	Fax #	(901) 745-7251
AOD	(855) 828-4717	AOD	(615) 218-0784	AOD	(866) 925-4204

PERSON SUPPORTED INFORMATION **DIDD REGION**: [ ] East [ ] Middle [ ] West

NAME: ____________________ **DATE OF BIRTH**: ____________________

SOCIAL SECURITY NO: ____________________ **AGE AT DEATH**: ____________________

RACE: [ ] White [ ] Black [ ] Hispanic [ ] Other **SEX**: [ ] Male [ ] Female

CLASS MEMBER STATUS: [ ] Settlement Agreement [ ] Not applicable

FUNDING STATUS [ ] "Statewide" Waiver [ ] "Self-Determination" Waiver [ ] Private ICF/IID

[ ] CAC Waiver [ ] State-Funded [ ] Developmental Center [ ] State ICF/IID

RESIDENCE

[ ] Lived with family [ ] Supportive Living [ ] Private ICF/IID

[ ] Lived in Own Home with Support [ ] Residential Habilitation [ ] Developmental Center

[ ] Lived Independently [ ] Medical Residential Services [ ] Nursing Facility

[ ] Family Model Residential Services [ ] Other (explain) ____________________

DID THE PERSON SERVED MOVE IN THE PAST 6 MONTHS? [ ] No [ ] Yes (specify date: ____________________)

DATE OF DEATH: ____________________ **DATE REPORTED**: ____________________ **TIME REPORTED**: ____________________ AM / PM

PLACE OF DEATH [ ] Home [ ] Psychiatric Facility

[ ] Hospital [ ] Other (explain) ____________________

DETAILS OF DEATH

1. **AUTOPSY REQUESTED?** [ ] No [ ] Yes, If so, by whom ____________________
2. **MEDICAL EXAMINER CONTACTED?** [ ] No [ ] Yes, If so, by whom ____________________
3. **CORONER CONTACTED?** [ ] No [ ] Yes, If so, by whom ____________________
4. **INCIDENT FORM SUBMITTED?** [ ] No [ ] Yes

INDICATE WHO HAS BEEN NOTIFIED

[ ] ISC/Case Manager [ ] Legal Representative [ ] Family [ ] DIDD Investigator [ ] Police

NAME OF PRIMARY CARE PROVIDER: ____________________ **PHONE NO**: ____________________

TYPE OF CASE MANAGER [ ] ISC [ ] State Case Manager [ ] QMRP

NAME OF CASE MANAGER: ___________________________________ **PHONE NO**: __________________

NAME OF ISC AGENCY: ___________________________________ **PHONE NO**: __________________

NEXT OF KIN and/or **LEGAL REPRESENTATIVE**: ____

GENERAL HEALTHCARE INFORMATION

NAME OF PERSON SUPPORTED: ____

AMBULATION: [ ] Ambulatory
[ ] Non-Ambulatory

COMMUNICATION: [ ] Verbal
[ ] Non-verbal

NUTRITION: [ ] Eats Independently
[ ] Eats w/ Assistance
[ ] Tube fed

WEIGHT IS: [ ] Normal Weight
[ ] Overweight
[ ] Underweight

WEIGHT: ________
HEIGHT: ________

PHYSICAL STATUS REVIEW (if applicable) **DATE OF LAST PSR:** _______________ **PSR LEVEL:** _______________

MEDICATIONS:

INTELLECTUAL DISABILITY [ ] Mild [ ] Moderate [ ] Severe [ ] Profound [ ] Unknown / Unspecified

Etiology (if known): ____

BEHAVIORAL / PSYCHIATRIC DIAGNOSES:

GENERAL MEDIACAL DIAGNOSES:

HOSPITALIZATIONS / PROCEDURES (over the past 12 months)

Reason for Hospitalization / Procedure:	Treatment Location:	Date:

____ ____________________

Name of Provider, Private ICF/IID, or DIDD Developmental Center **Phone Number**

____ ____________________

Person Completing this Form (please print) **Title**

____ ____________________

Signature **Date**