Appendix G – Clinical Mortality Data Request Form

Please complete the **attached 3 pages** and return them along with the information listed below **within 30 days** as part of the final report of your follow-up related to the recent death of an individual supported by your facility. Please send this information to the Mortality Review Committee via the mortality drop box or fax to 502-564-2386

Please mark each item requested as 'enclosed' or 'not applicable'. If a requested document is determined to be 'not applicable', please provide the reason.		
Department for Behavioral Health, Developmental and Intellectual Disabilities Mortality Review Report	☐ Enclosed ☐ Not Applicable	
Internal Mortality Review Information	☐ Enclosed ☐ Not Applicable	
Final Expanded Investigation	☐ Enclosed ☐ Not Applicable	
Admission Psychiatric Assessment	☐ Enclosed ☐ Not Applicable	
Admission History and Physical	☐ Enclosed ☐ Not Applicable	
Most Recent History & Physical	☐ Enclosed ☐ Not Applicable	
Psychosocial Admission Information	☐ Enclosed ☐ Not Applicable	
Physician's Progress Notes **3** months	☐ Enclosed ☐ Not Applicable	
Medical Consultation Reports **6** months	☐ Enclosed ☐ Not Applicable	
Labs performed in the past **6** months	☐ Enclosed ☐ Not Applicable	
Discharge Report or Death Summary	☐ Enclosed ☐ Not Applicable	
Root Cause Analysis, if applicable	☐ Enclosed ☐ Not Applicable	
Nurse's Notes for the past **2** months	☐ Enclosed ☐ Not Applicable	
Admission Assessment	☐ Enclosed	

	☐ Not Applicable	
MAR's for the past **2** months	☐ Enclosed ☐ Not Applicable	
Current Psychological Evaluation	☐ Enclosed ☐ Not Applicable	
Incident Reports for the past **3** months	☐ Enclosed ☐ Not Applicable	
Autopsy Report, if applicable	☐ Enclosed ☐ Not Applicable	
Code Sheet, if Applicable	☐ Enclosed ☐ Not Applicable	
Copy of Advance Directive, DNR, Living Will, or Health Care Directive, if applicable	☐ Enclosed ☐ Not Applicable	

Medical Care

Individual's Name:

MAID #:	Date Of Birth:	Date Of Death:

Primary Care Physician (PCP)	**# of visits in past year**
Name: _____ Tel: _____ Date last seen: _____ PCP changed in the past year? ☐ NO ☐ YES	

Medical Specialists

Dr's Name and Specialty Type	**Reason for Visit**	**# of visits in past year**

Emergency Room/Urgent Care Clinic Visits in Past Year:

Date of Visit	**Name of Hospital**	**Reason for Visit**

Hospital Admissions in Past Year:

Dates of Hospital Stay	**Name of Hospital**	**Reason for Admission**	**Attending Physician**

Please provide details regarding any history of tobacco, alcohol, or illegal drug use.