Death Documentation

Purpose: Record information from death certificate or other approved sources of information that verify the fact of death.

When: Within 5 days of receiving a copy of a death certificate or other approved source of verification of death.

By whom: Clinic coordinator.

Instruction: After completion of this form, send to the CC along with copies of death certificate or supplemental source(s) of death information with identifying information concealed. File the death certificate or other source information with the Patient Location Information form.

A. Clinic and patient identification

1. Clinic ID: ____ ____ ____ ____

2. Patient ID#: ____ ____ ____ ____

3. Patient name code: ____ ____ ____ ____ ____

4. Date form completed:

____ ____–____ ____ ____–____ ____
day month year

5. Visit ID code: N ____ ____

B. Death certificate information

6. Death certificate obtained:

(Yes 1) (No 2)

10. ┘

7. Date of death:

____ ____–____ ____ ____–____ ____
day month year

8. Cause of death

a. Underlying cause of death:

_____

_____

b. Due to (as a consequence of) #1:

_____

_____

c. Due to (as a consequence of) #2:

_____

_____

d. Due to (as a consequence of) #3:

_____

_____

9. Other conditions

a. Other condition #1:

_____

b. Other condition #2:

_____

c. Other condition #3:

_____

If no information about diseases or conditions is listed on the death certificate, record "N" in item 8b. and/or 9a.

If death certificate obtained skip to item 13.

C. Other death documentation

10. Type of documentation:

_____

_____

_____

Record patient ID number, name code, and date of submission on other death documentation. Attach a copy (with identifying information concealed) to this form and submit to CC.

11. Date of death:

____ ____–____ ____ ____–____ ____
day month year

12. Information regarding cause of death:

_____

_____

_____

_____

_____

_____

_____

D. Administrative information

13. Date form reviewed:

____ ____–____ ____ ____–____ ____
day month year

14. Clinic coordinator ID: ____ ____

15. Clinic coordinator signature:

_____

FOR CC USE - ICD9 coding

16. Underlying cause:

____ ____ ____ ____ • ____ ____

17. Contributing #1:

____ ____ ____ ____ • ____ ____

18. Contributing #2:

____ ____ ____ ____ • ____ ____

19. Contributing #3:

____ ____ ____ ____ • ____ ____

20. Other conditions

a. other condition #1:

____ ____ ____ ____ • ____ ____

b. other condition #2:

____ ____ ____ ____ • ____ ____

c. other condition #3:

____ ____ ____ ____ • ____ ____