

Death Report

Purpose: Notify the Coordinating Center of a patient's death and collect information on the clinical assessment of the death from care provider or medical personnel.

When: Fax DR form [Fax# (410) 955-0932] to CC within 24 hours of the clinic being notified of a patient's death and call CC to confirm receipt of fax. (Do not send a second copy.)

By whom: Study physician and clinic coordinator.

Additional instructions: Fax the DR form to CC within 24 hours of being notified of patient's death. Submit other relevant forms including Followup Treatment History form and the Followup Medical History form to CC within 5 working days. Also submit the Death Documentation form (DD) when necessary information becomes available.

A. Clinic and patient identification

1. Clinic ID code: _____

2. Patient ID#: _____

3. Patient name code: _____

4. Date form completed:
_____ - _____ - _____
day month year

5. Visit ID code: _____ N _____

B. Death information

6. Date of death:
_____ - _____ - _____
day month year

7. Source of death notification (*check all that apply*)

- a. Medical record: ()
- b. Medical examiner: ()
- c. Coroner: ()
- d. Funeral parlor/home: ()
- e. Patient's family: ()
- f. Friend: ()
- g. Health care provider: ()
- h. Newspaper: ()
- i. Other (*specify*): ()

_____ other source

8. Place of death (*check only one*):

Hospital/hospice ()

Home ()

Other (*specify*): ()

_____ other place

Unknown ()

9. Location of place of death:

_____ state/province/country

10. Has the death certificate been received:

() Yes () No

If death certificate has been received, complete Death Documentation form. If not received, initiate death certificate request from State Vital Records office.

11. Study physician's opinion as to immediate cause of death:

12. Study physician's opinion as to contributing cause(s) of death:

C. Administrative information

13. Date form reviewed:

____ - ____ - ____
day month year

14. Study physician ID: _____

15. Study physician signature:

16. Clinic coordinator ID: _____

17. Clinic coordinator signature:
