Death Report

State of Minnesota
Office of the Ombudsman for Mental Health and Developmental Disabilities
FAX: 651-797-1950

Date: _____ County: Select a County

Client Information

Last Name: _____ First Name: _____ MI: _____

Name of Residential Facility/Provider
Client resided prior to death: _____

Street Address: _____

City: _____ State: Select or Type State Zip: _____

Telephone Number: _____ Gender: Choose One Client Date of Birth: _____

Type of License: Choose One or Type in _____

Ethnic: Choose One Was client on or eligible for Medical Assistance: Choose Yes or No

Guardianship: Choose One

Legal Status: Choose One

Disability: Choose One

Reporter Information

Last Name: _____ First Name: _____

Title: _____

Street Address: _____

City: _____ State: Select or Type State Zip Code: _____

Telephone Number: _____ Fax: _____

Death Information

Name of Facility where death occurred: _____

Street Address: _____

City: _____ State: Select or Type State Zip Code: _____

Date admitted to place of death: _____

Date of Death: _____ Time of Death: _____ AM

Death Type: Choose One

Was death expected? Choose Yes or No DNR/DNI Order: Choose Yes or No

Limited Treatment: Choose Yes or No Autopsy: Choose Yes or No

Cause of Death:

Diagnosis

Axis 1 (Clinical Syndromes):

Axis II (Developmental/Personality Disorders):

Axis III (Physical Disorders):

Current Medications and Dosages:

Other Agencies Involved/Referred to/Notified:

- ☐ Legal
- ☐ Administration
- ☐ Ombudsman
- ☐ DHS
- ☐ OHFC
- ☐ County
- ☐ State Agency
- ☐ Private Agency
- ☐ Treatment Team
- ☐ MH Association
- ☐ Medical
- ☐ Other Government
- ☐ Adult/Child Protection/CEP

Circumstances surrounding death: (may send incident report)

Revised 11/12

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