



Maryland Department of Health and Mental Hygiene

Mental Hygiene Administration

Spring Grove Hospital Center – Dix Building
55 Wade Avenue – Catonsville, Maryland 21228

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

In accordance with the requirements of Health-General Article, §10-714, Annotated Code of Maryland, the administrative head of a facility/program must report the death of an individual who was receiving or had received mental health services from the program/facility. Upon notification of the individual's death, the administrative head of a program/facility shall report the death (1) immediately to the sheriff, police or chief law enforcement official in the jurisdiction in which the death occurred, and (2) by the close of business of the next working day to the Director of the Mental Hygiene Administration, the Health Officer in the jurisdiction in which the death occurred, and the designated State protection and advocacy agency. The initial report may be oral if followed by a written report within 5 working days from the date of the death. Additionally, the administrative head of a residential program or inpatient facility shall report the death of any individual who received mental health services from the program/facility and who died within 14 days of discharge or release, if any program/facility services are funded through the public mental health system or operated by the Mental Hygiene Administration under Health General §§10-406, 10-901 or 10-902.

PART I. Deceased's Information

A. Demographics

Name of Deceased: (Last, First) _____

Deceased's Gender: Male Female Age _____ Date of Birth: (mm/dd/yyyy): _____

Date (mm/dd/yyyy) and Time of Death: _____

Social Security #: _____ Medical Assistance #: _____

Do Not Resuscitate Order? Yes No Unknown

Name of Facility/Program Reporting the Death: _____

Address of Facility/Program: _____

County program is located in: _____

Contact person and phone number: _____

Date Admitted/Enrolled with Provider: _____ Medical Record Number: _____

Type of Services the Deceased Received within the last 30 days (Check all that apply):

Inpatient RTC Assisted Living PHP IOP OMHC PRP RRP Respite

Mobile Treatment Crisis Response Residential Crisis Case Management

Mental Health Vocational Program Other _____

Living Arrangements: Lived Alone Lived with Family/Significant Other Lived in MHA funded program

If lived in MHA funded program, print name & telephone number of operator:

Community Address of the Deceased at Time of Death (Street Address, City and State):

Location of body at time of death: Deceased's Residence Other (specify) _____

Deceased Consumer: _____

The place where the body was found at above location (e.g. bedroom): _____ Unknown

Date and Time of Provider's Discovery of Death: _____

Source Where Information was Obtained Regarding Death: _____

Name of Deceased's Next Of Kin or Legal Guardian (If Known): _____

Address: _____ Telephone Number: _____

B. Notifications (include Date, Time and Name of Staff Notified of the Death)

Name (printed) and Telephone Number of Person Responsible for the Legally Required Notifications of the Report of Death: _____

Law Enforcement Official: _____ Date/Time: _____

Jurisdiction: _____ Police Report # _____

Health Officer: _____ Date/Time _____

Designated State Protection and Advocacy Agency: _____ Date/Time: _____

Cause of Death: _____

Death Possibly Occurred (Check One)*:

Suddenly, if the deceased was in apparent good health Suicide Accident Natural causes

In any suspicious or unusual manner Act of violence

*If death occurred for any reason other than "natural causes", please elaborate in Section III

Autopsy to be performed? Yes No Unknown

Name/Title/Telephone number of person taking custody of body (**print**): _____

Name and Title of person evaluating the death, if known (**print**): _____

Part II. Clinical/Community Provider Information (Complete Each Section, Note **NA** if it Does Not Apply)

A. Provider Information

Name & title of provider reporting death: _____

Date last seen by provider reporting death: _____

Treating Psychiatrist and telephone number: _____

Case Manager and telephone number: _____

Primary Therapist and telephone number: _____

Medical Care Physician and telephone number: _____

Was patient hospitalized for medical or psychiatric reasons within 30 days of death? Yes No Unknown

If yes, where and for what reason: _____

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Web Site: www.dhmm.state.md.us

Deceased Consumer: _____

B. Diagnoses. List all Medical/Psychiatric diagnoses known to be current during last 30 days (NOTE: **DO NOT USE CPT CODES**):

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

C. Medications.

List the deceased's current medications, including PRN's, and if known, those prescribed by other providers

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

D. Allergies: _____ None Known

E. History of Aggression or Violence toward Self or Others _____

F. Legal Involvement: _____

Part III. Supplemental Information

Provider to add information believed relevant and not requested on this form. Attach separate page if needed. If information is obtained via an obituary notice, please attach a copy of the obituary.

Deceased Consumer: _____

For deaths believing to have occurred by (1) Violence; (2) Suicide; (3) Casualty (accident); (4) Suddenly, if the deceased was in apparent good health; or (5) In any suspicious or unusual manner, the Provider shall report any other information the administrative head of the facility or program determines relevant to the medical examiner, police, sheriff, or chief law enforcement official in the jurisdiction in which the death occurred, the Director of the Mental Hygiene Administration, the Health Officer and the designated State protection and advocacy agency.

Part IV. Contact Information

Printed Name and Telephone Number of Person Submitting the Form

Signature of Person Submitting the Form

Date

CONFIDENTIALITY NOTICE

This document contains confidential information. Disclosure of this document could be a violation of the Maryland Confidentiality of Medical Records law. REDISCLOSURE IS STRICTLY PROHIBITED, unless made pursuant to HG §4-302(d) of the Annotated Code of Maryland.

IF YOU RECEIVE THIS DOCUMENT IN ERROR, PLEASE IMMEDIATELY NOTIFY THE SENDER TO ARRANGE THE RETURN OF THE ORIGINAL DOCUMENT(S).

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