

**Berrien Mental Health Authority**

**REPORT OF DEATH / CLINICAL SUMMARY**

DATE OF REPORT:

**RECIPIENT INFORMATION**

**Completed by Case Manager, Primary Clinician or Clinical Assistants**

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| --- | --- | --- |
| Recipient Name: | Case Number: | Medicaid ID Number: |
| Address: | | Living Situation: (do they live in a licensed home, with family, a general AFC, be specific) |
| Date you were notified of death: | | How were you notified about the death: (phone call, email, text, explain here) |
| Date of Death: (must be accurate) | | Place of Death: (home, hospital, community, where were they when they died, be specific, this is needed to request the death certificate, autopsy and police reports as applicable) |
| Primary Clinician Name: | | Person Completing Form if different from Primary Clinician: (Entering your name is also your signature) |

**TREATMENT INFORMATION  
Completed by Recipient Rights Department**

|  |  |
| --- | --- |
| Last hospitalized in Psychiatric Hospital: | Last hospitalized (in State Psychiatric (KPH), DD Center, Child Caring Institution, and location if within 1 year from date of death):  Date:  Location: |
| Was the Recipient receiving Hospice Care: | Was the Recipient in a medical hospital prior to or at the time of death: |
| *Can insert a screen shot of Diagnosis Code and Description* | |
| Primary ICD 10 Diagnosis Code: | Description: |
| Secondary ICD 10 Diagnosis Code: | Description: |
| ICD 10 Diagnosis Code: | Description: |
| ICD 10 Diagnosis Code: | Description: |
| ICD 10 Diagnosis Code: | Description: |
| Provide a summary of the conditions the consumer is receiving Mental Health Services for including recent changes.  (\**include what authorized services were provided within* ***last one year****, Medications, Therapy, Targeted Case Management, Comprehensive Case Management, ACT, Supports Coordination, HAB Waiver, CLS/frequency & duration, Specialized Residential – Type A or B, etc… this is not an exhaustive list*): | |
| Summary of Physical Health Status including recent changes: (as found in progress notes or documents in IRIS) | |
| Medications prescribed by Agency Physician within last 30 days: (as found in IRIS) | |
| Cause of Death as reported to -or- as identified in death certificate if available when completing this form: *(\*if suicide include method, if accidental include type of accident and how it occurred, if natural give specific cause, was it expected or unexpected):* | |

**RECIPIENT DEATH FOLLOW UP**

|  |  |
| --- | --- |
| Death Certificate | Date requested: |
| Has an autopsy been ordered? | If yes, date requested: |
| Is there a Police Report? | If yes, date requested: |

Signature: Date:

*Completed form is submitted to the Records Department*