STATE OF CONNECTICUT

DEPARTMENT OF DEVELOPMENTAL SERVICES

# DEATH REPORT FORM

## Region/TS: NR SR WR STS

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Report Date: | |  | | | | Time: | : |  |  | Death Date: |  | | | Time: | | : | |  |  |
| Individual’s Name: | | | |  | | | | | | | DDS#: |  | | DOB: | | | |  | |
| Gender: | Male | | | | Female | | | | | | | | | | | | | | |
| Address: |  | | | | | | | | | | | | | | | | | | |
| Residence Type: | | |  | | | | | | | | | | Phone No.: | | (   ) | | - | |  |

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| Location of Death: |  | | | | | | | | | | | |
| Cause of Death: |  | | | | | | | | | | | |
| Was death anticipated as the result of a known condition? | | | | | | Yes  No | | | | DNR Order? | | Yes  No |
| Was death accidental? | | Yes  No | | | | | | | | | | |
| OCME contacted: | Yes No | | | Date: |  | OCME# | |  | | (860) 679-3980 / 1-800-842-8820 | | |
| Accepted jurisdiction? | | Yes  No | | | | | | | | | | |
| Private autopsy requested: | | | Yes  No | | Consent obtained? | | Yes  No | | Performed by: | |  | |

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| --- | --- | --- | --- |
| Is Abuse or Neglect Suspected? | Yes  No | Was an Abuse/Neglect Report Completed? | Yes  No |

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| (NOTIFICATION) ALL DEATHS | | | | | | |
| DDS Case Manager | Name: |  | | | Date: |  |
| Family  Guardian Advocate | Name: |  | | | Date: |  |
| Regional Director (On-Call Mgr.) | Name(s): |  | | | Date: |  |
| DDS Health Service Director | Name: |  | | | Date: |  |
| (NOTIFICATION) UNEXPECTED DEATHS | | | | | | |
| Director of Health & Clinical Services (860-418-6083) | | | Name: | Gloria Jones | Date: |  |
| Director of Investigations (860-418-8725) | | | Name: | Kendres Lally | Date: |  |
| Local/State Police | | | Name: |  | Date: |  |
| Abuse/Neglect Suspected Contact AID (844-878-8923) | | | Name: |  | Date: |  |

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| UNEXPECTED DEATHS   * Death that was not expected or anticipated as a result of any previously known medical diagnosis or condition * Death as a result of an accident (car accident, fall, choking, etc.) even if the person had a known terminal condition * Death that was due to a suspected/alleged homicide or suicide * Death for which there is an allegation of abuse or neglect | | | |
| 1. Police involvement: | Yes  No | 3. Conduct on-site visit: | Yes  No |
| 2. Secure records/environment: | Yes  No | 4. Complete Immediate Safety Assessment Form: | Yes  No |

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| OTHER DETAILS | | | |
|  | | | |
| Completed by (Name & Title): |  | Date: |  |

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| Reporter’s Name, Title & Agency: | | | | |  | | | | | Date: | |  |
| Address: | |  | | | | | | | | | | |
| Phone: | - | | - |  | City: |  | State: |  | Zip Code: | |  | |

Distribution: Original: Consumer Master File/Case Manager

Copies: Director of Health & Clinical Services – CO, Health Services Director, Regional Director, Nurse Investigator,

Director of Investigations Fax# 860-920-3182