REPORT OF DEATH TO THE JUSTICE CENTER

Form JC v 1 *Justice Center Incident Report Confirmation #*

Justice Center Incident Report Confirmation #

Red boxed information is required write unknown if applicable

Date Report Prepared: _____

Name: (Last,First) Date of Birth: Age:

Gender: Race: Height - Feet: - Inches: Weight: lbs.

SSN: _____

Section 1: Reporting Agency/Facility/Program Data

Name of reporting Agency :

Address:

Executive Director/ CEO: Telephone:

Name of Person Preparing Report: Telephone:

Title of Person Preparing Report:

Name of Contact Person for this Report: Telephone:

Title of Contact Person:

Name and Address of Specific Program/Facility,
Within the Agency, Which Served the Recipient:

Date of admission to this program: Agency/Program/Facility Operated/Certified/Licensed By: SOA

Section 2: Recipient information

Recipient's Service Relationship to Agency/Facility/Program:

☐ Resided in an Operated/Certified/Licensed; type of program Type of program

☐ Received Only non-residential services

Is the individual receiving service from any other program under the jurisdiction of NYS? Yes ☐ No ☐

If yes, give name and address of responsible agency(ies)

Mental Disability Diagnosis (including Substance Abuse Diagnosis):

1. Yes ☐ No ☐ ICD Code Enter Diagnosis or N/A

2. Yes ☐ No ☐ ICD Code Enter Diagnosis or N/A

3. Yes ☐ No ☐ ICD Code Enter Diagnosis or N/A

4. Yes ☐ No ☐ ICD Code Enter Diagnosis or N/A

If additional space is needed use the end of the form!

Date of last ER visit for psychiatric or Substance abuse reasons: from: To:

Date of last hospitalization for psychiatric or substance abuse reasons: from: To:

REPORT OF DEATH TO THE JUSTICE CENTER

Form JC v 1 *Justice Center Incident Report Confirmation #*

Section 2: Recipient information Continued

Physical Illness/Conditions Diagnosed Prior to Death-ICD Codes if available:

1. Yes ☐ No ☐ ICD Code Enter Diagnosis or N/A

2. Yes ☐ No ☐ ICD Code Enter Diagnosis or N/A

3. Yes ☐ No ☐ ICD Code Enter Diagnosis or N/A

4. Yes ☐ No ☐ ICD Code Enter Diagnosis or N/A

Date of last ER visit for physical reasons from: To:

Date of last hospitalization for physical reasons: from: To:

Medications at time of death:

Medication	Dose (in mg.)	Frequency	Route

Section 3: Death Data

Date of Death: Pronounced Time of Death: : ☐AM ☐PM

Location Where Individual Died: Location Address Actual Time of Death: : ☐AM ☐PM

County of Death:

Location Classification:

Cause of Death: Immediate Cause

Due to or as a consequence of

Due to or as a consequence of

REPORT OF DEATH TO THE JUSTICE CENTER

Justice Center Incident Report Confirmation #

Section 3: Death Data Continued

Manner of Death:

Was an Autopsy Completed: ☐ Unknown ☐ NO ☐ Yes ME/Coroner case number

Source of Cause of Death and Manner of Death is:

Name and Telephone Number

Within 24 hours of death was recipient: [ ] On DNR/DNI status [ ] Given stat/PRN medication for behavioral or psychiatric reasons

Is there any indication that this death may:

- ☐ have resulted from an accident
- ☐ have resulted from a homicide
- ☐ have resulted from a suicide
- ☐ have resulted from a medication error
- ☐ have resulted from a medication/drug overdose
- ☐ have resulted from the use of a controlled substance or alcohol
- ☐ have resulted from the attempted use of restraint
- ☐ have resulted from the attempted use of seclusion/time out
- ☐ be an unexplained death
- ☐ be an unexpected death

Section 4: Narrative Summary

Describe the recipient's psychiatric, behavioral and medical status within 90 days prior to Death

Routine medical follow-up

Primary care visit :

Routine speciality care visit:

- cardiologist
- gastroenterologist
- urologist
- gynecologist
- neurologist
- orthopedist
- pulmonologist
- other (specify)

Section 4: Narrative Summary continued

Acute medical issue

- ☐ Choking
- ☐ Fall
- ☐ Seizure
- ☐ Weight loss lbs.
- ☐ Weight gain lbs.
- ☐ Change in bowel habits
- ☐ Change in bladder habits
- ☐ Change in ambulation
- ☐ Change in food intake
- ☐ Change in medication
- ☐ Change in fluid intake

other (specify)

Acute psychiatric issue

- ☐ Change in psychiatric status
- ☐ Change in behavior planning/supervision

other (specify)

Describe the safeguards and diet, if ordered, specifically for recipient:

Safeguards

other (specify)

Diet Ordered for Decedent

Food	Fluid
☐ no special diet	☐ no altered consistency
☐ cut to specific size	☐ thin
☐ chopped	☐ thickened
☐ ground	☐ nectar thick
☐ soft	☐ honey thick
☐ pureed	☐ pudding thick

other (specify)

Section 4: Narrative Summary continued

Were all components of the eating plan followed at the time of death?

Indicate significant changes in the 90 day period prior to death that impacted the recipient.

Please check applicable boxes

* Changes in service providers

☐ residence ☐ program ☐ case manager/MSC ☐ transportation ☐ medical provider

* Changes in treatment regimen

☐ medication ☐ diet ☐ supervision ☐ behavior plan ☐ treatment plan

* Changes in level of functioning

☐ Decline in physical health ☐ Decline in mental health

☐ Required increased assistance with ADLs ☐ Required increased monitoring/supervision

☐ Required higher level of care ☐ placed on hospice ☐ comfort care

DESCRIBE CIRCUMSTANCES LEADING UP TO AND INCLUDING DEATH.

REPORT OF DEATH TO THE JUSTICE CENTER

Form JC v 1

Justice Center Incident Report Confirmation #

Clear Form

Print Form