Community Mental Health Partnership of Southeast Michigan
SUD Services Report of Death

Please complete information as best as possible – if dates or information is unknown, note as such.

Date of Report: _____

Client Name:_____ **E 2 Case No.**_____**DOB** _____

Sex: _____ **Race:** _____ **Date and Time of Death**_____

Place of Death _____

- ☐ **Expected** ☐ **Unexpected Death** ☐ **Known or Suspected Overdose**
- ☐ **Critically Ill** ☐ **Seriously Ill** D ☐ **Chronically Ill** ☐ **No Illness Known**

(*Check expected or unexpected and illness classification.)*

Tentative Cause of Death:_____

Date of last discharge: ***(From psychiatric hospital, medical hospital, Residential or Detox, IOP, Recovery Housing etc.)***_____

Date last seen by TX Provider Staff_____**Case Mgr.**_____**Peer**_____

Diagnosis:
Psychiatric/SUD:_____

Medical: _____

Medications: (*Dose, route, and time administered, if known)*_____

Known Substances Used in Last 30 days: _____

_____

_____

Laboratory tests, EKGS, and X-Rays supporting medical diagnoses:

_____

Relevant past medical history supporting medical diagnoses:

_____

_____

_____

Relevant and/or recent medical and surgical treatment or recent changes in medical status:

_____

_____

_____

Any unusual circumstances surrounding death: ***(If accidental death includes the type of accident and how it occurred. If suicide, include if history of previous attempts known, indication for precautions, precautionary measures taken, and method used by the client.)***

_____

_____

_____

_____

Summary of Medical Condition and treatment immediately preceding death (*Including any life support measures taken. If transferred to a general hospital, include date and time.)*

_____
_____
_____

Was Client on a Wait list for treatment? ***If so, include level of care waiting for and time waiting._***

Was Client recently released from Jail? _____
_____
_____

Complete form as completely as possible. Attach additional sheets if needed.

_____

Submit completed form to CMHPSM Clinical/SUD Directors Office within 24 hours of

_____ **Date**____
Signature and title of staff completing form

_____**Date**____
Supervisor signature and title