MARYLAND
Department of Health

Behavioral Health Administration Report of Death

Behavioral Health Administration
Office of Government Affairs
Spring Grove Hospital Center – Dix Building
55 Wade Avenue – Catonsville, Maryland 21228 Fax: 410.402.8332

In accordance with the requirements of Health-General Article, §10-713, please complete the following information. *NOTICE: Effective 10/1/15, for purposes of reporting of deaths, "program or facility" means an inpatient or residential treatment setting, residential crisis service, group home, or residential rehabilitation program (see House Bill 1109 – 2015).* ***Only the aforementioned programs/facilities must comply with this reporting requirement.***

A. Demographics

- Name of decedent: (last, first)
- Decedent's gender: ☐ Male ☐ Female
- Decedent's date of birth: _____
- Decedent's age: _____
- MA #_____
- SS #_____
- Date of discovery of death: _____
- Decedent's place of residence at time of death (street address, city and state): _____
- Place where the body was found (e.g. bedroom, bathroom, field, unknown): _____
- If death occurred in a place other than the residence of the decedent, the location of the body at the time of discovery: _____
- Name of the person who took custody of the body: _____
- Name of the person evaluating the death, if known: _____
- Autopsy to be performed? ☐ Yes ☐ No ☐ Unknown
- Name of decedent's next of kin or legal guardian (if known): _____

  Address: _____ Telephone number: _____

B. Clinical/Community Provider Information

- Name of facility/program reporting the death: _____
- Address of facility/program: _____

  County in which program is located: _____
- Name & telephone number of person completing form: _____

Decedent's Name: _____

- Date admitted/enrolled with provider: _____
- Date last seen by provider: _____
- Treating psychiatrist and telephone number: _____
- Primary therapist and telephone number: _____
- Medical care physician and telephone number: _____
- Case manager and telephone number: _____
- Services decedent received prior to death: ☐ OMHC ☐ PRP ☐ RRP
  ☐ Mental Health Vocational Program ☐ Mobile Treatment ☐ Crisis Response
  ☐ Residential Crisis ☐ Assisted Living ☐ IOP ☐ PHP ☐ RTC ☐ Respite
  ☐ Case Management ☐ Inpatient, Psychiatric ☐ Inpatient, Medical
  ☐ Other _____
- **If decedent was hospitalized within 30 days of death, please indicate where and for what reason:**

  _____

C. Diagnoses. List **all medical/psychiatric** diagnoses known to be current during the 30 days prior to death.

DSM 5: _____

D. Medications. List decedent's current medications, including PRN's, and if known, those prescribed by other providers.

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

E. Allergies: _____ ☐ None known

F. History of aggression/violence toward self or others: _____

G. Legal involvement, if any: _____

H. Possible cause of death:

☐ Natural ☐ Act of violence ☐ Suicide - method used: _____ ☐ Casualty
☐ Suddenly, if the deceased was in apparent good health ☐ Suspicious or unusual manner

Decedent's Name: _____

- **Please provide information believed relevant to the above cause(s) of death** . Attach separate page if needed. If information is obtained via an obituary notice, please attach a copy of the obituary.

I. Notifications. The initial report may be (1) oral, if followed by a written report within 5 working days from date of the death, or (2) written; notifications are required to be completed within the time constraints listed below for either method of initial reporting. If the possible cause of death is believed to be anything but 'natural', the provider shall report the death, in addition to all parties listed below, to the medical examiner.

Please check notifications performed.

- Immediate Notification Required:
  - ☐ Law Enforcement Official in the jurisdiction in which the death occurred; and
  - ☐ The Secretary of the Maryland Department of Health.
- Notification required by close of business of the next working day:
  - ☐ The Deputy Secretary/Executive Director of the Behavioral Health Administration;
  - ☐ The Health Officer in the jurisdiction where the death occurred; and
  - ☐ The designated State protection and advocacy system. Please fax a copy of this form to Disability Rights Maryland at 410.727.6389.
- Other notification:
  - ☐ The Medical Examiner (if the cause of death is believed to be other than 'natural')

J. Contact Information.

Printed name & title of person submitting form: _____

Telephone number: _____

Signature of individual submitting form:

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).