



FAX THIS REPORT AND RETURN ORIGINAL TO:

Office of Health Facility Licensure & Certification  
Attention: Behavioral Health Program  
408 Leon Sullivan Way  
Charleston, WV 25301-1713  
P: (304) 558-0050  
F: (304) 558-2515

LOG NUMBER \_\_\_\_\_

DATE \_\_\_\_\_

**OFFICIAL USE ONLY**

NOTE: This form must be submitted within 24 hours of notification of consumer death. An internal investigation must be conducted and submitted to OHFLAC within 14 days. If an ICF/IID client, an internal investigation is to be conducted and submitted to the facility's administrator within 5 days and OHFLAC within 14 days.

**CONTACT INFORMATION**

Facility Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Reported By: \_\_\_\_\_  
*Last First M.I.*

**CONSUMER INFORMATION**

Was the deceased a residential or supported living consumer?  Yes  No

Full Name: \_\_\_\_\_  
*Last First M.I.*

Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_  
*Street Address Apartment / Unit #*  
\_\_\_\_\_  
*City State ZIP Code*

**CONSUMER TREATMENT**

Admission Date: \_\_\_\_\_

Services provided to consumer by facility: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical and psychiatric diagnoses within the last year, if available: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications prescribed at time of death: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**EVENT DETAILS**

Was death reported to coroner?  Yes  No

Date of Death: \_\_\_\_\_ Time of death: \_\_\_\_\_  A.M.  P.M.

Date consumer last seen by facility staff: \_\_\_\_\_

Location of consumer at time of death: \_\_\_\_\_

Location of consumer during initial illness/accident leading to death: \_\_\_\_\_

Staff Present during initial illness/accident leading to death: \_\_\_\_\_

Antecedents prior to death: \_\_\_\_\_

\_\_\_\_\_

Medical interventions performed onsite: \_\_\_\_\_

\_\_\_\_\_

Brief description of events: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Advance directives consumer may have had: \_\_\_\_\_

\_\_\_\_\_

Preliminary cause of death, if known: \_\_\_\_\_

\_\_\_\_\_

**SIGNATURE**

I certify that this report and the information I have provided is accurate and complete to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_