



FAX THIS REPORT AND RETURN ORIGINAL TO:

Office of Health Facility Licensure & Certification  
Attention: Chronic Pain Management 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 a patient death. Additional sheets may be attached as needed, to report the information in its entirety.

**CLINIC INFORMATION**

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street Address

City

State

ZIP Code

Phone: ( ) \_\_\_\_\_

Fax: ( ) \_\_\_\_\_

Name and Title of Person Completing Form: \_\_\_\_\_

**PATIENT IDENTIFIERS**

Name of Patient : \_\_\_\_\_

City of Residence: \_\_\_\_\_

County of Residence: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_

Sex:  Male  Female

**PATIENT MEDICAL INFORMATION**

Date Patient was last treated in the clinic: \_\_\_\_\_

Results of most recent urine drug screen analysis: \_\_\_\_\_

Date Completed: \_\_\_\_\_

Diagnoses within the past year: \_\_\_\_\_

Medications prescribed at time of death (including dosage): \_\_\_\_\_



**REPORTING DETAILS**

Was death reported to the medical examiner?  Yes  No

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

Suspected Cause of Death: \_\_\_\_\_

How was the clinic made aware of the patient's death? \_\_\_\_\_

**DETAILS OF EVENT**

Describe the details of the mortality, as reported to your clinic: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INVESTIGATION**

Describe the details and outcome of any investigation conducted by your clinic: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE**

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

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