LARA Use Only

Date Received
Facility Number

PSYCHIATRIC NOTIFICATION OF DEATH REPORT
Psychiatric Inpatient Hospital/Unit

Michigan Department of Licensing and Regulatory Affairs (LARA)
Health Facilities Licensing, Permits and Support Division
State Licensing Section
611 W. Ottawa Street, P. O. Box 30664
Lansing, MI 48909

Rule 330.1274 requires the administrator, or designee, to inform the department, as soon as administratively possible, of all deaths in the licensed psychiatric hospital unit.

Reporting Hospital				**Report Date**
(Name)				(mm/dd/yyyy)
(Address)				
(City)		(State)	(ZIP Code)	(Phone)
Hospital/Program Administrator				
(Name)				(Phone)
Initials of Patient	Medical Record #	Age	Gender (M/F)	Admission Date (mm/dd/yyyy)
Axis I admitting diagnosis:				
Axis III admitting diagnosis:				
Cause of Death			Time of Death	Date of Death (mm/dd/yyyy)

Provide brief statement of circumstances of the patient's admission to the psychiatric program:

*Attach copy of Admission History and Physical (Attachment #1)

If patient expired after discharge/transfer from the licensed psychiatric program, please note the date of discharge/transfer and location/program to which the patient was transferred/discharged.

* Attach copies of all (medical/psychiatric) discharge or transfer summaries (Attachment #2)

While hospitalized in the psychiatric or medical unit, was the patient secluded or restrained?

☐ Yes ☐ No If yes, note type of intervention(s) and date(s):

Did the death:
☐ occur while the patient was restrained or secluded, or
☐ occur within 24 hours after the patient was restrained or secluded, or
☐ occur within 1 week after the patient was restrained or secluded.

Did the use of restraint or seclusion contributed directly or indirectly to the death?

☐ No ☐ Unknown pending completion of investigation ☐ Yes

If a patient died in the community, provide the location or address where patient died, manner of death, manner of discovery of patient's death, occurrence of any events that may have contributed or precipitated the patient's death.

Provide description of life saving measures taken by hospital.

At the time of death, was the patient on a “DO NOT RESUSCITATE [DNR]” status?

☐ No ☐ Yes If YES, note:

(i) the date that the patient was placed on the DNRs status (mm/dd/yyyy)

(ii) the relationship of the individual authorizing the DNR status

Was the program's recipient rights advisor notified of the patient's death? ☐ No ☐ Yes

If yes, please note the date and time of notification: (mm/dd/yyyy) (time)

Steps taken by hospital to investigate the circumstances of the patient's death and review the quality and appropriateness of care provided to the patient.

Was local law enforcement agency notified of the patient's death? ☐ No ☐ Yes

If yes, indicate name and phone number of investigating officer(s) and name of law enforcement jurisdiction.

Was the medical examiner (ME) notified of the patient's death? ☐ No ☐ Yes

If yes, did ME take jurisdiction of this case? ☐ No ☐ Yes

If yes, provide ME office phone number, ME Case/Post #, and ME name/contact person.

* Forward copy of the postmortem report when received by the hospital.

To your knowledge, was an autopsy completed? ☐ No ☐ Yes ☐ Not Sure

If yes, by whom:

Send completed form to:

Psychiatric Death Notification
State Licensing Section
Bureau of Community and Health Systems
MI Dept of Licensing & Regulatory Affairs
P.O. BOX 30664
Lansing, Michigan 48909

bchs-statelicensing@michigan.gov

Submitting Authority:

_____

(Patient's physician/chief of psychiatry sign)

(Type name of signing physician)

The Michigan Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. You may make your needs known to this Agency under the *Americans with Disabilities Act* if you need assistance with reading, writing, hearing, etc.