Attachment A

# STATE OF CONNECTICUT
# DEPARTMENT OF DEVELOPMENTAL SERVICES
# DEATH REPORT FORM

**Region/TS:** ☐ **NR** ☐ **SR** ☐ **WR** ☐ **STS**

| Report Date: | Time: | Death Date: | Time: |
|---|---|---|---|
| Individual's Name: | | DDS#: | DOB: |
| Gender: ☐ Male ☐ Female | | | |
| Address: | | | |
| Residence Type: | | | Phone No.: |

| | | | |
|---|---|---|---|
| Location of Death: | | | |
| Cause of Death: | | | |
| Was death anticipated as the result of a known condition? ☐ Yes ☐ No | | DNR Order? ☐ Yes ☐ No | |
| Was death accidental? ☐ Yes ☐ No | | | |
| OCME contacted: ☐ Yes ☐ No | Date: | OCME# | (860) 679-3980 / 1-800-842-8820 |
| Accepted jurisdiction? ☐ Yes ☐ No | | | |
| Private autopsy requested: ☐ Yes ☐ No | Consent obtained? ☐ Yes ☐ No | Performed by: | |

| Is Abuse or Neglect Suspected? ☐ Yes ☐ No | Was an Abuse/Neglect Report Completed? ☐ Yes ☐ No |
|---|---|

## (NOTIFICATION) ALL DEATHS

| | | |
|---|---|---|
| ☐ DDS Case Manager | Name: | Date: |
| ☐ Family ☐ Guardian ☐ Advocate | Name: | Date: |
| ☐ Regional Director (On-Call Mgr.) | Name(s): | Date: |
| ☐ DDS Health Service Director | Name: | Date: |

## (NOTIFICATION) UNEXPECTED DEATHS

| | | |
|---|---|---|
| ☐ Director of Health & Clinical Services (860-418-6083) | Name Gloria Jones | Date: |
| ☐ Director of Investigations (860-418-8725) | Name Kendres Lally | Date: |
| ☐ Local/State Police | Name | Date: |
| ☐ Abuse/Neglect Suspected Contact AID (844-878-8923) | Name | Date: |

## UNEXPECTED DEATHS

- Death that was not expected or anticipated as a result of any previously known medical diagnosis or condition
- Death as a result of an accident (car accident, fall, choking, etc.) even if the person had a known terminal condition
- Death that was due to a suspected/alleged homicide or suicide
- Death for which there is an allegation of abuse or neglect

| | |
|---|---|
| 1. Police involvement: ☐ Yes ☐ No | 3. Conduct on-site visit: ☐ Yes ☐ No |
| 2. Secure records/environment: ☐ Yes ☐ No | 4. Complete Immediate Safety Assessment Form: ☐ Yes ☐ No |

## OTHER DETAILS

| Completed by (Name & Title): | Date: |
|---|---|

| | | | |
|---|---|---|---|
| Reporter's Name, Title & Agency: | | | Date: |
| Address: | | | |
| Phone: | City: | State: | Zip Code: |

Distribution: Original: Consumer Master File/Case Manager
Copies: Director of Health & Clinical Services – CO, Health Services Director, Regional Director, Nurse Investigator, Director of Investigations Fax# 860-920-3182

**Revised 12/22**