Attachment F

[Name of Provider] **Sample ~~~~ Mortality Review Worksheet ~~~~ Sample**	
Individual's Name:	
Date of Birth:	Date of Death:
Gender: ☐ Male ☐ Female	Date of Review:
Location at Time of Death: ☐ Residence ☐ Emergency Room ☐ Hospital ☐ Hospice ☐ Other: _____	
Attending Physician:	
Cause of Death (As noted on Death Certificate)	
Do Not Resuscitate (DNR) Order? ☐ Yes ☐ No	
Diagnoses at time of death: (list all or attach list)	
Medications at time of death: (list all or attach list)	
☐ No Autopsy Performed ☐ Autopsy Performed	
☐ Expected Mortality ☐ Unexpected Mortality ☐ Mortality Not Expected On Admission to Hospital/ER but Expected at Time of Death	
☐ Individual had an Advance Directive ☐ Individual did not have an Advance Directive	

Screening

✓*Yes*	✓*No*	*Check appropriate box for each question*
☐	☐	If Death was unexpected, was a root cause analysis performed?
☐	☐	Individual Under 50 years of age?
☐	☐	Death within 48 hours of a dental, surgical, radiology or invasive procedure?
☐	☐	Death associated with drug reaction?
☐	☐	Death associated with a serious incident?
☐	☐	Death associated with seizure?
☐	☐	Death within 48 hours of admission to hospital or ER?
☐	☐	Did individual have a known terminal illness?
☐	☐	Changes noted in the individual's condition in the 72 hours before death?
☐	☐	If death not in hospital, was CPR initiated?
☐	☐	If death not in hospital, were staff with individual at time of death?

Conclusions

✓*Yes*	✓*No*	*Check appropriate box for each question*
☐	☐	Opportunities for improvement identified. Action needed.
☐	☐	No opportunities for improvement noted. No action needed.