Statistical Data

Print or Type all information *(Submit completed form to the DMRS Regional Office within one business day after becoming aware of the death Provider Manual 11.17.a)*

I. DECEDENT INFORMATION

Name_____ SSN_____ DOB_____

Gender_____ Race_____ Date of last Physical Status Review (PSR)____/____/____ Level_____

A. MEDICATIONS 1._____ 7._____

2._____ 8._____

3._____ 9._____

4._____ 10._____

5._____ 11._____

6._____ 12._____

B. DIAGNOSES

1. MR Level_____ Etiology (if known) _____

2. Behavioral/Psychiatric

a._____ d._____

b._____ e._____

c._____ f._____

3. General Medical Diagnoses

a._____ f._____

b._____ g._____

c._____ h._____

d._____ i._____

e._____ j._____

C. HOSPITALIZATIONS/PROCEDURES HISTORY (last 6 months)

	Procedure/Problem	Treatment Location	Date
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

II. OTHER INFORMATION

Ambulation: non amb _____ amb _____

Nutrition: tube _____ eats independ._____ eats w/assist. _____

Communication: verbal _____ non verbal _____ other _____

Nutritional Support Status (weight) over_____ normal_____ under_____ Ht_____ Wt_____

Has moved within: six months? Yes No 60 days? Yes No 30 days? Yes No 14 days? Yes No

Print or Type

COMPLETED BY:_____ _____ _____

NAME	TITLE	TEL. NO.