



# Death Report

State of Minnesota  
Office of the Ombudsman for Mental Health and Developmental Disabilities  
FAX: 651-296-1021 or 651-797-1950



Date:

County:

## Client Information

Last Name:

First Name:

MI:

Name of Residential Facility/Provider  
Client resided prior to death:

Street Address:

City:

State:

Zip:

Telephone Number:

Gender:

Client Date of Birth:

Type of License:

Ethnic: Is client o

Was client on or eligible for Medical Assistance:

Guardianship:

Legal Status:

Disability:

## Reporter Information

Last Name:

First Name:

Title:

Street Address:

City:

State:

Zip Code:

Telephone Number:

Fax:

## Death Information

Name of Facility where death occurred:

Street Address:

City:

State:

Zip Code:

Date admitted to place of death:

Date of Death:

Time of Death:

Death Type:

Was death expected?

DNR/DNI Order:

Limited Treatment:

Autopsy:

Cause of Death:

## Diagnosis

Axis 1 (Clinical Syndromes):

Axis II (Developmental/Personality Disorders):

Axis III (Physical Disorders):

Current Medications and Dosages:

Other Agencies Involved/Referred to/Notified:

Legal

County

MH Association

Administration

State Agency

Medical

Ombudsman

Private Agency

Other Government

DHS

Treatment Team

Adult/Child Protection/CEP

OHFC

Circumstances surrounding death: (may send incident report)