



# Maryland Department of Health and Mental Hygiene

## Mental Hygiene Administration

Spring Grove Hospital Center – Dix Building

55 Wade Avenue – Catonsville, Maryland 21228

Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Nelson J. Sabatini, Secretary

In accordance with the requirements of Health-General 10-714, Annotated Code of Maryland, upon notification of the individual's death, an oral report shall be submitted immediately to the sheriff, police or chief law enforcement official in the jurisdiction in which the death occurred and to the DHMH Secretary and by the close of business the next working day to the MHA Director, the Health Officer in the jurisdiction in which the death occurred and the Maryland Disability Law Center, the State's designated State protection and advocacy agency. In addition, upon notification of an individual's death, the administrative head of the program or facility shall complete a written report of death, using this form within 5 working days from the date of the death. The administrative head of the program or facility shall report the death of any individual who resided in or was receiving mental health services at the time of death or who died within 14 days of discharge or release from any program or facility for which services are funded through the public mental health system or operated by the Mental Hygiene Administration under Health General 10-406, 10-901 or 10-902.

### A. Demographics

Name of Deceased: (Last, First) \_\_\_\_\_

Deceased's Gender:  Male  Female Age \_\_\_\_\_ Date of Birth: (mm/dd/yyyy) \_\_\_\_\_

Date (mm/dd/yyyy) and Time of Death: \_\_\_\_\_  Unknown\_\_

Social Security #: \_\_\_\_\_ Medical Assistance #: \_\_\_\_\_

Do Not Resuscitate Ordered?  Yes  No

Name of Facility/Program Reporting the Death \_\_\_\_\_

Date Admitted/Enrolled with Provider: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

Type of Services the Deceased Received within the last 30 days (Check all that apply):

Inpatient  RTC  Assisted Living  PHP  IOP  OMHC  PRP  RRP  Respite

Mobile Treatment  Crisis Response  Residential Crisis  Case Management

Mental Health Vocational Program  Other \_\_\_\_\_

Living Arrangements:  Lived Alone  Lived with Family/Significant Other  Lived in MHA funded program

If lived in MHA funded program, print name & telephone number of operator:  
\_\_\_\_\_

Community Address of the Deceased at Time of Death (Street Address, City and State):  
\_\_\_\_\_

Location of Body at Time of Death:  Deceased's Residence  Other (specify) \_\_\_\_\_

Date and Time of Provider's Discovery of Death: \_\_\_\_\_  Unknown

The Place Where the Body Was Found: \_\_\_\_\_  Unknown

Name of Deceased's Next Of Kin or Legal Guardian (If Known): \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Deceased Consumer: \_\_\_\_\_

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**B. Notifications** (include Date, Time and Name of Staff Notified of the Death)

Name (printed) and Telephone Number of Person Responsible for the Legally Required Notifications of the Report of Death: \_\_\_\_\_

Law Enforcement Official: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Jurisdiction: \_\_\_\_\_ Police Report # \_\_\_\_\_

Health Officer: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Maryland Disability Law Center: \_\_\_\_\_ Date/Time: \_\_\_\_\_

**Cause of Death:** \_\_\_\_\_

**Death Possibly Occurred** (Check If Appropriate):

Suddenly, If The Deceased Was In Apparent Good Health  Suicide  Accident  Natural

Causes  In Manner Any Suspicious Or Unusual  Act of Violence

Autopsy To Be Performed?  Yes  No  Unknown

Name/Title/Telephone Number of Person Taking Custody of Body (print): \_\_\_\_\_

Name and Title of Person Evaluating the Death, If Known (print): \_\_\_\_\_

**Part II. Clinical/Community Provider Information** (Complete Each Section, Note **NA** if it Does Not Apply)

Name, Title of Provider and Date Last Seen by Provider Reporting Death: \_\_\_\_\_

Treating Psychiatrist and Telephone Number: \_\_\_\_\_

Case Manager and Telephone Number: \_\_\_\_\_

Primary Therapist and Telephone Number: \_\_\_\_\_

Medical Care Physician and Telephone Number: \_\_\_\_\_

Was patient hospitalized for medical or psychiatric reasons within 30 days of death?  Yes  No  Unknown

If yes, where and for what reason: \_\_\_\_\_

**A. Diagnoses.** List all Medical / Psychiatric diagnoses known to be current during last 30 days:

AXIS I: \_\_\_\_\_

AXIS II: \_\_\_\_\_

AXIS III: \_\_\_\_\_

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Web Site: [www.dhmh.state.md.us](http://www.dhmh.state.md.us)

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Deceased Consumer: \_\_\_\_\_

AXIS IV: \_\_\_\_\_

AXIS V: \_\_\_\_\_

**B. Medications.**

List the deceased's current medications, including PRN's, and if known, those prescribed by other providers

MEDICATION	DOSE	FREQUENC Y	MEDICATION	DOSE	FREQUENC Y

**C. Allergies:** \_\_\_\_\_

**G None Known**

**D. History of Aggression or Violence toward Self or Others** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**E. Legal Involvement:** \_\_\_\_\_

**Part IV. Supplemental Information**

Provider to add information believed relevant and not requested on this form. Attach separate page if needed.

For deaths believing to have occurred by (1) Violence; (2) Suicide; (3) Casualty (accident); (4) Suddenly, if the deceased was in apparent good health; or (5) In any suspicious or unusual manner, the Provider shall report shall any other information the administrative head of the facility or program determines should be provided to the medical examiner, police, sheriff, or chief law enforcement official in the jurisdiction in which the death occurred, the Secretary, the Director, the Health Officer and the State protection and advocacy system.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Deceased Consumer: \_\_\_\_\_

**Part V. Contact Information**

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Printed Name and Telephone Number of Person Submitting the Form

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Signature of Person Submitting the Form

Date