

OCCURRENCE REPORTING FORM

Please complete the following information. **ALL SECTIONS MUST BE COMPLETED!** Incomplete reports will not be accepted unless the facility indicates that it is an initial report with further information to follow. Note that "client" refers to the patient or resident who is the subject of the occurrence.

DEATH

"Any occurrence that results in the death of a patient or resident of the facility and is required to be reported to the Coroner pursuant to Section 30-10-606, C.R.S., as arising from an unexplained cause or under suspicious circumstances." 25-1-124(2)(a), C.R.S.

2 ELEMENTS NEEDED:

(Check elements met)

- Occurrence resulting in death
- Reportable to the coroner as unexplained or suspicious

Facility Name: _____

Group Home Name (if applicable): _____

Facility Type: _____

If this is a hospital, where did the occurrence happen (Check appropriate unit):

- Acute Care Unit
- TCU
- Psych Unit (separate license)
- Rehab Unit (separate license)

Occurrence Number (noted on acknowledgement letter): _____

Name, title, and phone number of person reporting: _____

Occurrence Date: _____ Occurrence Time: _____

Date reported to HFEMSD: _____

If not reported to HFEMSD by the end of the next business day, why not?

CLIENT INFORMATION

If this occurrence involves more than one client, please provide the following requested information for each client involved. If necessary attach a separate sheet of paper.

Client Gender: Male Female

Client ID: _____
(This is anything that is a unique identifier for this client. In the event of an inquiry about this client sometime in the future, the facility needs to be able to identify the client involved.)

Age of Client: _____

Significant medical history:

Did death occur in a hospital? Yes No

Admission date: _____

Reason for admission:

Procedures performed during the hospital admission:

ALL SECTIONS MUST BE COMPLETED!

DESCRIPTION OF THE OCCURRENCE

1. Was the death the direct result of an occurrence in the facility? Yes No
If no, please review the elements needed for reportable death. If the cause of death is not available at this time, please indicate as such, and provide cause of death to HFEMSD as soon as it is available.
2. Did the coroner take the case? Yes No Unknown

Is an autopsy being done? Yes No Unknown
3. What were the circumstances of the death? Please describe:

4. Was the death the result of a suicide attempt? Yes No
If yes, was the client on suicide precautions? Yes No
Were these being followed? Provide description of the precautions:

5. Was the death the result of a restraint? Yes No
*If yes, this must be reported to CMS if this is a Medicare/Medicaid facility.
If yes, describe what happened:

*Was CMS notified? Yes No

Had client been restrained recently, or during the course of an admission? Yes No
If yes, please describe:

6. Was the death witnessed? Yes No

If yes, by whom? _____

7. Where did the death occur (client's room, operating room, facility grounds, etc)?

FACILITY ACTION

- 8. Was resuscitation attempted? Yes No
Did the client have advanced directives? Yes No
Were they honored? Yes No
- 9. Who pronounced the death? _____
- 10. Please describe the facility investigation and the results of the investigation (ie., interviews, documentation reviewed). Add extra pages if necessary:

- 11. Were facility policies and procedures followed? Yes No
If no, please describe:

- 12. What interventions were put in place to prevent a recurrence? Please describe:

NOTIFICATIONS

- 13. Who was notified of the occurrence? Check all that apply.
 Coroner (County): _____
 Police Dept Name: _____
Officer: _____ Case Number: _____
 Family/Guardian Physician Ombudsman Adult Protective Services
 Nursing Board Medical Examiners