



**MONTANA DEVELOPMENTAL DISABILITIES PROGRAM**  
**QIS Death Investigation Report and Checklist**

Name of Deceased: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Date/Time of Death: \_\_\_\_\_  
City: \_\_\_\_\_ Provider: \_\_\_\_\_  
QIS conducting investigation: \_\_\_\_\_

DDP notified of Death (within 8 hours, date and time, by whom, method):

**QIS DEATH INVESTIGATION REPORT**

1) Summary of Decedent's Services and Life Situation:

2) Description of Circumstances and Events Leading up to Death Event:

3) Description of Death Event:

4) Conclusions (Policies Followed, Staff Intervened Appropriately, etc.):

5) Recommendations for Provider:

**PERSON RECORDS:**

- |                              |                             |                             |   |
|------------------------------|-----------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |                             | Most current full plan of care and amendments                 |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Most recent Incident Reports (T-Logs as Appropriate)          |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Provider Case Notes/T-Logs (at least one week prior to death) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Current list of medications (if not in plan of care)          |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Medication Administration Record (previous two months)        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Case Manager's Case Notes                                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Updated medical condition if changes since plan of care       |

**MEDICAL:**

- |                              |                             |                             |  |
|------------------------------|-----------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Care plan for medical condition  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Procedures regarding specific medical needs (ie. feeding protocol, seizure protocol, etc.) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Guardianship (Court Documents)   |
|                              |                             |                             | Names and address, if possible of:   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Primary Care Physician: _____  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Other Medical Professionals: _____   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Hospital (Includes ER and/or Urgent Care): _____   |

**END-OF-LIFE DECISIONS/DNR ISSUES:**

- |                              |                             |                             |                            |
|------------------------------|-----------------------------|-----------------------------|----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Terminal Illness/Diagnosis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | DNR Order                  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Comfort One                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Living Will                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Hospice                    |

**PROFESSIONAL CARE RECORDS:**

- |                              |                             |                             |  |
|------------------------------|-----------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Any medical information available such as office notes, hospital records |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Ambulance Trip Report  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Police or MHP Report   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Death Certificate  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> NA | Coroner's Report (with autopsy report if done)                           |

\_\_\_\_\_  
Signature of QIS completing Review

\_\_\_\_\_  
Date