DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
CENTER FOR SUBSTANCE ABUSE TREATMENT

Form Approved: OMB Number 0930-0296
Expiration Date: 10/31/2011
See OMB Statement on Reverse

SAMHSA OTP Mortality Report

Date of Report: _____/_____/_____ **Follow-up report?** ☐

Note: This form will assist in the regulatory agency review of patients who die while enrolled in Opioid Treatment Programs certified to operate by SAMHSA. The goal is to improve the quality of care of these programs. **Please print all information clearly.**

A. Background Information

Patient's OTP ID No.: | | | | | | | | | | | | | |

Program OTP No.: (Same as SAMHSA ID) | | | – | | | | | | – | |

Patient's Date of Birth: _____/_____/_____ (e.g., mm/dd/yyyy)

Patient's ZIP Code of Residence: _____

Patient's Sex: Female ___ Male ___

Approximate Date of Death: _____/_____/_____ (e.g., mm/dd/yyyy)

Patient's Admission Date: _____/_____/_____ (e.g., mm/dd/yyyy)

Reporter's Name: _____ (e.g., last, first)

B. Date and Amount of Last Opioid Dose Dispensed Before Death:

Last Time Dosed at Clinic: _____/_____/_____ (e.g., mm/dd/yyyy)

Opioid: ___Methadone *or* ___Suboxone *or* ___Subutex

Last Dose: _____ mgs Please indicate if this is a split dose: ☐

Number of Take-Home Doses Dispensed at Last Visit: _____

C. Treatment Objective at Time of Death:

___Induction ___Maintenance ___Medically Supervised
___Other _____ Withdrawal (Detox)

D. Most Recent Drug Test Date: ____/____/_____ (e.g., mm/dd/yyyy)

Positive Results: _____

_____

E. Medical and Psychiatric Diagnosis:

(Provide ICD-9 codes)

Axis I _____ _____ _____ _____ _____
Axis II _____ _____ _____ _____ _____
Axis III _____ _____ _____ _____ _____
Axis IV _____ _____ _____ _____ _____
Axis V _____ _____ _____ _____ _____

For SUD:

☐ Early Remission ☐ Full Remission
☐ Partial Remission ☐ Controlled Environment

F. Preliminary (P) or Confirmed (C) Underlying Cause/Mechanism of Death:

P	C		P	C	
___	___	Unknown/Undetermined	___	___	Cardiovascular
___	___	Overdose	___	___	COPD
___	___	Motor Vehicle Accident	___	___	Diabetes
___	___	Other Type of Accident	___	___	HIV/AIDS
___	___	Homicide	___	___	Kidney Disease
___	___	Suicide	___	___	Liver Disease
___	___	Trauma	___	___	Seizures
___	___	Cancer	___	___	Other (list)

_____

G. List of Known OTC and Prescription Medications at the Time of Last Visit:

Medication Name	Strength	Dose/Amount	Frequency	Medication Name	Strength	Dose/Amount	Frequency
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

H. Description of Event (detailed description of the factors related to the patient's death, including where the death occurred, if others were involved, how the death was discovered, list of illicit drugs involved, etc.). If more space is needed, use a continuation sheet, as described in the general instructions accompanying this form.

I. Other Relevant Medical History (for example, allergies, pregnancy, preexisting medical conditions)**:**

J. Medical Examiner's/Coroner's Contact Information (if known)**:** *Please attach ME/Coroner's report or forward when available.*

Please fax to CSAT/DPT at 240– 276–1630. Patient and reporter identifiers reported to SAMHSA on this form will be kept confidential by SAMHSA and will not be disseminated outside of the Federal Government except as required by law or otherwise authorized under 42 CFR Part 2.

Purpose of Form: This form will assist in the regulatory agency review of patients who die while enrolled in Opioid Treatment Programs certified to operate by SAMHSA.

Paperwork Reduction Act Statement