

**DEPARTMENT OF MENTAL HEALTH
DECEASED CLIENT PROFILE**

Purpose: Persons with serious mental illness die significantly younger than the general population. In order to better understand the causes of this excess mortality, the Department of Mental Health is gathering information. This form, the "Deceased Client Profile" is completed for every client death. The information requested below provides the Area Medical Director client-specific information regarding the deceased. The data is also aggregated to assist the Area Office and Central Office in identifying trends in client's health and healthcare characteristics.

This is not an investigation and is completely separate from the DMH CMR 32 investigation process. Please answer every question. THANK YOU.

Name of Client: _____

Client's Age: _____

Date of Birth: _____

Male: **Female:**

Race:

Caucasian/White

Hispanic

African-American

Asian

Native American/Alaska Native

Native Hawaiian /Pacific Islander

Other

Did the deceased primarily identify him/herself as Hispanic/Latino?

Yes

No

Housing:

DMH Residence

Hospital

Supported Housing

Housing with Family

Housing with Others

Lived Alone

Other- *specify* _____

DSM DIAGNOSES

Major Diagnoses: *DSM code not needed*

AXIS I _____

AXIS II _____

A. Circumstances of Death:

1. Date of Death: _____

2. Presumed Manner of Death (what we *think* caused the death)

Natural Causes

Accident

Suicide

Homicide

3. Was this death expected?

Yes

No

4. Is an autopsy being conducted? Yes No

if yes, by whom:

Medical Examiner OR Hospital- *Name the Facility:* _____

5. Location of Death: Hospital Nursing Home Group Home Supported Housing

Apartment/Home (*presumes person lived independently*)

Other- *specify:* _____

B. Major Category Cause of Death

This chart is divided into four main sections: Natural causes, accident, suicide, and homicide.

First, GO TO the appropriate section. Then, check the appropriate category.

If category is not known, but presumed, check here: _____.

If you leave this section blank, go to page 4.

<input type="checkbox"/>	Section 1. Natural Causes: (Diseases)
<input type="checkbox"/>	1. Alzheimer’s Disease
<input type="checkbox"/>	2. Anemia
<input type="checkbox"/>	3. Atherosclerosis (hardening or thickening of arteries)
<input type="checkbox"/>	4. Cancer
<input type="checkbox"/>	a. Colon, rectum, or anus
<input type="checkbox"/>	b. Mesothelioma (<i>cancer of the lining around the heart, the lungs, or the abdomen</i>)
<input type="checkbox"/>	c. Trachea, bronchus, or lung
<input type="checkbox"/>	d. Breast
<input type="checkbox"/>	e. Prostrate
<input type="checkbox"/>	f. Other
<input type="checkbox"/>	5. Cerebrovascular disease (stroke)
<input type="checkbox"/>	6. Chronic liver disease and cirrhosis
<input type="checkbox"/>	7. Chronic lower respiratory disease (COPD: asthma, bronchitis, emphysema)
<input type="checkbox"/>	8. Diabetes
<input type="checkbox"/>	9. a. Heart Disease (heart attack)
<input type="checkbox"/>	b. Other heart disease
<input type="checkbox"/>	10. HIV or AIDS
<input type="checkbox"/>	11. Influenza & pneumonia
<input type="checkbox"/>	12. Kidney disease (chronic renal failure)
<input type="checkbox"/>	13. Meningitis (infection of brain and / or spinal cord)
<input type="checkbox"/>	14. OTHER
	Section 2. Accident
<input type="checkbox"/>	1. Motor vehicle injuries
<input type="checkbox"/>	2. OTHER
	Section 3. Suicide
<input type="checkbox"/>	1. Firearm
<input type="checkbox"/>	2. Hanging
<input type="checkbox"/>	3. Jumping
<input type="checkbox"/>	4. Overdose
<input type="checkbox"/>	5. OTHER
	Section 4. Assault (homicide)
<input type="checkbox"/>	1. Injury by firearms
<input type="checkbox"/>	2. OTHER

9. If specific cause of death known, please write it here: _____

C. **Deceased's Health Status:** (Smoking, Substance abuse, Obesity, Activity, Nutrition)

1. **Smoking:**

a. Did patient smoke within the six months prior to death?

- Yes, if yes: Approx. # packs / day _____ Approximate # of years used _____
 No

b. Did patient have a known history of ever smoking? (i.e. ex-smoker)

- Yes, if yes: Approx. # packs / day _____ Approximate # years used _____
 No

2. **Substance Abuse:**

a. Did the patient abuse alcohol within the six months prior to death?

- Yes No if yes: Approx. # years used _____

b. Did the patient ever have a known history of alcohol abuse (i.e. recovered alcoholic)

- Yes No if yes: Approx. # years used _____

c. Did the patient abuse illicit substances and/or Prescription Medications in the six months prior to his/her death:

- Yes No if yes, fill in Chart below

Name of Substance/Medication(s) **Approx # Months used** **Circle route(s)**

		IV Oral Snort Inhale Smoke Other: _____
		IV Oral Snort Inhale Smoke Other: _____
		IV Oral Snort Inhale Smoke Other: _____

d. Did the patient ever have a known history of medication or substance abuse?

Yes No *if yes, fill in chart below:*

Drug Name	Approx. Years Used	Circle route(s)
		IV Oral Snort Inhale Smoke Other: _____
		IV Oral Snort Inhale Smoke Other: _____
		IV Oral Snort Inhale Smoke Other: _____

3. Obesity:

If recorded in the chart, please note the most recent

height _____ft _____inches and **weight** _____lbs., and the **date**_____

Otherwise, please **estimate** the patient’s **height** _____ft _____inches and **weight** _____lbs.

Please note the patient’s BMI _____ *See attached table to record BMI (after last page of DCP)*

4. Activity:

For the two questions below, picture the client as he/she functioned in his/her daily routine. Please answer to the best of your knowledge.

a. Did the client’s health limit him/her in moderate activities such as moving a table, pushing a vacuum cleaner, or other regular daily activities

Yes, limited a lot Yes, limited a little No, not at all

b. Did the client’s health limit him/her in climbing several flights of stairs?

Yes, limited a lot Yes, limited a little No, not at all

5. Nutrition: *Please answer to the best of your knowledge.*

a. Was the client’s diet well balanced and include regular fruits and vegetables? Yes No

b. Did the client drink 4-8 glasses of water daily? Yes No

c. Was the client’s diet characterized by high fat, or high carbohydrate foods? Yes No

9. Did client see a medical specialist (other than primary care physician) for a chronic condition(s) listed above? Yes No

F. Recent Acute Medical Health Care Services:

1. In the last 3 months was client physically sick? Yes No *if yes, describe problem(s):*

2. Were any medications discontinued in the last 3 months? Yes No

If yes, list medication(s) and date(s) of discontinuation if known:

3. Did the client receive any *new* medical treatments (*not medication*) in the last 3 months?

Yes No *If yes, please list*

4. To the best of your knowledge, did the client accept the new medical recommendations? (Medications and/or Treatments?)

Yes No DK

G. Overall Compliance Issues

1. In general, did the client have a medical condition or exhibit physical symptoms that needed medical care?

Yes No

2. Did the client follow medical recommendations (medications and/or treatments)?

Mostly Sometimes Rarely Not at all

3. Indicate any issues that might have affected the client's utilization of medical services. *Check all that apply:*

Fear/denial of illness/cognitive limitations

↓organizational skills (*e.g., keeping appointments, managing medication*)

Psychiatric symptoms (*e.g., paranoid delusions or auditory hallucinations*)

Poor communication skills (*difficulty communicating medical problems*)

Communication Problems with Providers: (*client complained that medical providers were disrespectful, uninterested, poor communicators*)

Other: _____

H. Psychiatric:

1. Approximately, how many times per year did client see psychiatrist? _____ Date of last visit: _____

I. Competency Issues

1. Presumed Competent Yes No

2. Guardianship Yes No

If yes, specify:

Guardianship of Person (Usual & customary medical care)

Rogers (Substituted judgment for Medications)

3. Did client have a Health Care Proxy selected at the time of death? Yes No D/K

a. If yes, was Health Care Proxy involved in client's health care choices? Yes No N/A

b. Did client receive hospice or other end of life care services? Yes No N/A

J. Death Certificate Available? Yes No

If yes, please list cause(s)

Thank you for your cooperation in completing this form. Please sign last page!

Agency Conducting Review: _____

Name of Person Completing Review: *please print* _____ **Date** _____

Signature of Person Completing Review: _____

Title _____ **Phone** _____

Comments:

Your Supervisor's Name: *please print* _____ **Phone** _____

Thank you for taking the time to complete this form.

Please forward to: Area Medical Director

AREA OFFICE NOTES:

Body Mass Index (BMI)

The Body Mass Index is a practical marker to assess obesity. BMI is a recognized indicator of the optimal weight for health. To obtain a BMI, a mathematical calculation is performed using metric units (grams for weight and centimeters for height). The table below has been converted to English units (pounds for weight and feet/inches for height).

To obtain the BMI, simply note where the client's height and weight converge. Write this number in the appropriate space in the DCP.

BMI =	Healthy		Overweight				Obesity					Extreme Obesity				
	19	24	25	26	27	28	29	30	35	40	45	50	55	60	65	70
Height	Weight in pounds															
4' 10"	91	115	119	124	129	134	138	143	167	191	215	239	262	285	310	335
4' 11"	94	119	124	128	133	138	143	148	173	198	222	247	270	295	320	347
5' 0"	97	123	128	135	138	143	148	153	179	204	230	255	280	305	332	358
5' 1"	100	127	132	137	143	148	153	158	185	211	238	264	290	315	343	370
5' 2"	104	131	136	142	147	153	158	164	191	218	246	273	300	325	358	386
5' 3"	107	135	141	146	152	158	163	169	197	225	254	282	310	338	368	395
5' 4"	110	140	145	151	157	163	169	174	204	232	262	291	320	349	375	407
5' 5"	114	144	150	156	162	168	174	180	210	240	270	300	329	360	390	420
5' 6"	118	148	155	161	167	173	179	186	216	247	278	309	340	371	402	433
5' 7"	121	153	159	166	172	178	185	191	223	255	287	319	350	382	414	446
5' 8"	125	158	164	171	177	184	190	197	230	262	295	328	361	394	427	459
5' 9"	128	162	169	176	182	189	196	203	236	270	304	338	372	405	439	473
5' 10"	132	167	174	181	188	195	202	209	243	278	313	348	383	416	452	487
5' 11"	136	172	179	186	193	200	208	215	250	286	322	358	394	426	465	501
6' 0"	140	177	184	191	199	206	213	221	258	294	331	368	405	442	478	515
6' 1"	144	182	189	197	204	212	219	227	265	302	340	378	416	454	492	530
6' 2"	148	186	194	202	210	218	225	233	272	311	350	389	429	466	505	544
6' 3"	152	192	200	208	216	224	232	240	279	319	359	399	439	479	519	559
6' 4"	156	197	205	213	221	230	238	246	287	328	369	410	451	492	533	574

Modified from National Institutes of Health, Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, 1998, and further developed for MA DMH by funds from RWJ "End of Life Care for Persons with Serious Mental Illness", 2002.