BP-A0563
JUN 10

MULTI-LEVEL MORTALITY REVIEW

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS

Date: _____

To: _____

From: _____

Subject: _____

Inst: _____

Name: _____ Reg. #: _____

DOD : _____ DOB: _____ Age: _____ Sex: _____ Race: _____

Place of Death: ☐ Inst. ☐ Community Hospital ☐ OTHER

Name of community hospital: _____

Nature of Death: ☐ Natural (chronic) ☐ Natural (Acute)

☐ Accidental: _____

☐ Homicide

☐ Suicide (Method) _____

Cause(s) of Death:

_____

_____

NARRATIVE SUMMARY: (Should include components below)

Date of admission to the _____

☐ New commit ☐ Transfer from _____ _____ Holdover

Status: ☐ Inpatient at: ☐ Inst. ☐ Community Hospital ☐ Outpatient

Admitting

1. _____
2. _____
3. _____
4. _____

(Pls. continue on supplementary page if necessary)

Past diagnosis:

1. _____
2. _____
3. _____
4. _____

(Pls. continue on supplementary page if necessary)

Significant mental health ☐ (Yes) ☐ (No) ☐ (NA)

Include specific information as relevant to death:

_____

_____

_____

Name: _____ Reg. #: _____ DOB: _____

Admitting diagnosis:(continue)

Past diagnosis: (Continue)

Description of course of illness (past and present) and cause of the death in sufficient detail to indicate circumstances of death, including treatment, medications, diagnostic testing, e tc. Give findings of diagnostic exams. Insert pages in this section as required.

Intake Screening History and Physical present? ____Yes ____No ____NA

Date of most recent History and Physical _____

Timeliness of Diagnostic and Treatment regimes? ____Yes ____No ____NA

Discharge summary from Attending M.D. on chart

Institution ____Yes ____No ____NA

Community Hospital ____Yes ____No ____NA

Autopsy ____Yes ____No ____NA

Toxicology ____Yes ____No ____NA

Death Certificate Available ____Yes ____No ____NA

INSTITUTION MEDICAL CARE REVIEW:

Severity of illness at time of admission to hospital / Health Services Unit ____ Critical ____ Stable ____ Unknown

Prognosis on admission to hospital / health Services Unit ____ Poor ____ Good ____ NA

Were diagnostic procedures appropriate and timely ____Yes ____No

Was treatment appropriate to diagnosis and instituted timely ____Yes ____No

Prognosis with treatment ____ Poor ____ Good ____ Unknown

Any complications adversely affecting outcome: ____Yes ____No

Describe briefly _____

_____

_____

_____

Was treatment appropriate to complication ____Yes ____No

Surgical Procedures (list) _____ ____Yes ____No ____NA

_____

_____

_____

Appropriate pre-operative evaluation completed, including lab, physical exam, updated history ____Yes ____No ____NA

Complications related to surgical procedures ____Yes ____No ____NA

(describe) _____

_____

_____

_____

Prognosis following surgical procedure ____ Poor ____ Good ____ Unknown

Patient compliant with treatment / medications ____Yes ____No ____NA

Discussion with patient or patient's family regarding prognosis ____Yes ____No ____NA

DNR order ____Yes _____ Date ____No

Advance Directive / Living Will ____Yes ____No ____NA

LOCAL COMMUNITY HOSPITALIZATIONS ONLY:

Type of admission ____Routine ____Emergent ____ Other

Method of transportation appropriate to patient condition ____Yes ____No ____ NA

Severity of condition at time of admission to local hospital ____ Critical ____ Stable ____ Unknown

Prognosis on admission to local hospital ____ Poor ____ Good ____ Unknown

Were diagnostic procedures appropriate and timely ____Yes ____No

Was treatment appropriate to diagnosis and instituted timely ____Yes ____No

Prognosis with treatment ____ Poor ____ Good ____ Unknown

Any complications adversely affecting outcome: ____Yes ____No

(describe briefly) _____

_____

_____

_____

Was treatment appropriate to complication ____Yes ____No

Surgical Procedures (list) _____ ____Yes ____No

_____

_____

_____

Appropriate pre-operative evaluation completed, including lab, physical exam, updated history ____Yes ____No

Complications related to surgical procedures ____Yes ____No

Describe _____

_____

_____

_____

Prognosis following surgical procedure ____ Poor ____ Good ____ Unknown

Patient compliant with treatment / medications ____Yes ____No ____NA

Discussion with patient or patient's family regarding patient prognosis ____Yes ____No ____NA

DNR order ____Yes _____ Date ____No

Advance Directive / Living Will ____Yes _____ Date ____No

REVIEW OF EMERGENCY MEDICAL CARE:

Was death related to a medical emergency	____Yes	____No	
Response to medical emergency			
notification timely	____Yes	____No	____NA
Physician	____Yes	____No	____NA
Physician Assistant		____No	____NA
Nurse Practitioner		____No	____NA
Nurse(s)	____Yes	____No	____NA
Emergency Medical Techs	____Yes	____No	____NA
Others	____Yes		
	____Yes		
CPR	____Yes	____No	____NA
ACLS List protocol (s) used (if appropriate)	____Yes	____No	____NA

_____

_____

_____

Problems encountered during medical emergency, e.g., equipment, communications, transportation. ____Yes ____No ____NA

Describe briefly: _____

_____

_____

_____

_____

Providers responding maintain current certification / credentials in BCLS, ACLS (if required) ____Yes ____No ____NA

SUMMARY REVIEW:

Documentation in medical record reviewed by Mortality Review Committee and found to be within acceptable limits. If no, describe _____ ____Yes ____No ____NA

Did patient receive appropriate and adequate health care, consistent with community standards, during his incarceration in the Federal Bureau of Prisons? If no, explain ____Yes ____No ____NA

State any strengths and weaknesses that existed:

27. Recommendation(s) if any.

28. Attachments:

____1. Medical Record
____2. Narrative Summary
____3. Death Certificate
____4. Autopsy Report
____5. Other Documents as appropriate (list) _____

_____

_____

ALL INFORMATION CONTAINED IN THIS REPORT IS EXEMPT AND TO BE CONSIDERED FOR REVIEW/VIEWING ON A NEED TO KNOW BASIS ONLY.

REVIEW COMMITTEE:

_____, A-W, (M)
_____, (CD)
_____, HSA
_____, QAC
_____D of N
_____, PA

OFFICE OF THE REGIONAL DIRECTOR

Comments:

☐ Agree with Institution MRC

☐ Disagree with Inst. MRC

Recommendations or Action taken:

Regional HSA _____ Date _____

Regional Director _____ Date _____

Comments:

Signature of Review Committee Member