REPORT OF DEATH TO THE JUSTICE CENTER

Form JC-2 v 1

Completed forms can be submitted via fax to 518-457-3503 or 518-549-0465 (back-up) or by mail to the NYS Justice Center for the Protection of People with Special Needs at 401 State Street, Schenectady, NY 12305.

Justice Center Incident Report Confirmation # _____

Red boxed information is required write unknown if applicable

Date Report Prepared: _____

Name: (Last, First) _____ Date of Birth: _____ Age: _____

Gender: -- _____ Race: -- _____ Height – Feet: ____ ____ - Inches: ____ ____ Weight: _____ lbs.

SSN: _____

Section 1: Reporting Agency/Facility/Program Data

Name of reporting Agency: _____

Address: _____ City: _____ State (abr): _____ Zip code: _____

Executive Director/ CEO: _____ Telephone: _____

Name of Person Preparing Report: _____Telephone: _____

Title of Person Preparing Report: _____

Name of Contact Person for this Report: _____ Telephone: _____

Title of Contact Person: _____

Name and Address of Specific Program/Facility, Within the Agency, Which Served the Recipient:

_____

Date of admission to this program: _____ Agency/Program/Facility Operated/Certified/Licensed By: SOA: -- _____

Section 2: Recipient information

Recipient's Service Relationship to Agency/Facility/Program

Type of program: _____

☐ Resided in an Operated/Certified/Licensed; type of program

☐ Received Only non-residential services

Is the individual receiving service from any other program under the jurisdiction of NYS? ☐ Yes ☐ No

If yes, give name and address of responsible agency(ies):

_____

Mental Disability Diagnosis (including Substance Abuse Diagnosis):

1. Yes ☐ No ☐ ICD Code _____ Enter Diagnosis or N/A
2. Yes ☐ No ☐ ICD Code _____ Enter Diagnosis or N/A _____
3. Yes ☐ No ☐ ICD Code _____ Enter Diagnosis or N/A _____
4. Yes ☐ No ☐ ICD Code _____ Enter Diagnosis or N/A _____

_____

If additional space is needed use the end of the form!

Date of last ER visit for psychiatric or Substance abuse reasons: From: _____ To: _____

Date of last hospitalization for psychiatric or substance abuse reasons: From: _____ To: _____

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Section 2: Recipient information Continued

Physical Illness/Conditions Diagnosed Prior to Death-ICD Codes if available:

1. Yes ☐ No ☐ ICD Code _____ Enter Diagnosis or N/A

2. Yes ☐ No ☐ ICD Code _____ Enter Diagnosis or N/A _____

3. Yes ☐ No ☐ ICD Code _____ Enter Diagnosis or N/A _____

4. Yes ☐ No ☐ ICD Code _____ Enter Diagnosis or N/A _____

_____
If additional space is needed use the end of the form!

Date of last ER visit for physical reasons: From: _____ To: _____

Date of last hospitalization for physical reasons: From: _____ To: _____

Medications at time of death:

Medication	Dose (in mg.)	Frequency	Route

Section 3: Death Data

Date of Death: _____ Pronounced Time of Death: ___ ___: ___ ___ ☐ AM ☐ PM

Location Where Individual Died: Location Address Actual Time of Death: ___ ___: ___ ___ ☐ AM ☐ PM

_____ _____

County of Death: --_____

Location Classification: _____

Cause of Death: Immediate Cause:

_____

Due to or as a consequence of: _____

Due to or as a consequence of: _____

Section 3: Death Data Continued

Manner of Death: _____

Was an Autopsy Completed: ☐ Unknown ☐ NO ☐ Yes ME/Coroner case number: _____

Source of Cause of Death and Manner of Death is:

_____

Name and Telephone Number

_____ _____

Within 24 hours of death was recipient: Unknov On DNR/DNI status -- Given stat/PRN medication for behavioral or psychiatric reasons

Section 4: Narrative Summary

Describe the recipient's psychiatric, behavioral and medical status within 90 days prior to Death

_____

Routine medical follow-up Primary care visit: _____

Routine specialty care visit:

Cardiologist: _____

Gastroenterologist _____

Urologist _____

Gynecologist _____

Neurologist _____

Orthopedist _____

Pulmonologist _____

other (specify) _____ _____

Section 4: Narrative Summary continued

Acute medical issue

- ☐ Choking
- ☐ Fall
- ☐ Seizure
- ☐ Weight loss ___ ___ ___ lbs.
- ☐ Weight gain ___ ___ ___ lbs.
- ☐ Change in bowel habits
- ☐ Change in bladder habits
- ☐ Change in ambulation
- ☐ Change in food intake
- ☐ Change in medication
- ☐ Change in fluid intake
- ☐ other (specify)

Acute psychiatric issue

- ☐ Change in psychiatric status
- ☐ Change in behavior planning/supervision

Other (specify) _____

Describe the safeguards and diet, if ordered, specifically for recipient:

Safeguards

_____

Other (specify)

_____

Diet Ordered for Decedent

Food

- ☐ no special diet
- ☐ cut to specific size
- ☐ chopped
- ☐ ground
- ☐ soft
- ☐ pureed

Fluid

- ☐ no altered consistency
- ☐ pudding thick
- ☐ honey thick
- ☐ nectar thick
- ☐ thickened
- ☐ thin

other (specify): _____

Section 4: Narrative Summary continued

Were all components of the eating plan followed at the time of death? --

Indicate significant changes in the 90-day period prior to death that impacted the recipient.

Please check applicable boxes

* Changes in service providers

☐ residence ☐ program ☐ case manager/MSC ☐ transportation ☐ medical provider

* Changes in treatment regimen

☐ medication ☐ diet ☐ supervision ☐ behavior plan ☐ treatment plan

* Changes in level of functioning

☐ Decline in physical health ☐ Decline in mental health

☐ Required increased assistance with ADLs ☐ Required increased monitoring/supervision

☐ Required higher level of care ☐ placed on hospice ☐ comfort care

DESCRIBE CIRCUMSTANCES LEADING UP TO AND INCLUDING DEATH.

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Clear Form

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Print Form