PSYCHIATRIC RESIDENTIAL TREATMENT FACILTIES (PRTF)
DEATH REPORTING WORKSHEET

CONTACT INFORMATION	
RO contact's name	
Date of RO contact	
RO contact's phone number	
Facility contact	
Facility contact's phone number	

PROVIDER INFORMATION	
PRTF Name	
Medicaid Number	
Address	
ZIP Code	

PATIENT INFORMATION	
Name	
Date of Birth	
Medicaid Number	
Admitting Diagnoses	
Date of Admission	
Date/time of Death	
Cause of Death	
Did the facility conduct a root cause analysis? (If so, please describe)	

NOTE: PRTFs may provide the following information over the telephone, or to the State Agency (SA) during its investigation

NOT RESTRAINT/SECLUSION RELATED - Yes___ No____
If yes to prior question, please specify length of time in restraints/seclusion:
Circumstances Surrounding the Death:
Results of any facility investigation:

RESTRAINT or SECLUSION INFO	**NOT RESTRAINT RELATED**
Restraint Method:	Accident:
Personal:	Medical Condition:
Mechanical:	Other:
Drug used as Restraint:	
Seclusion:	
Reason(s) for Restraint or Seclusion use:	

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RESTRAINT or SECLUSION INFO	**NOT RESTRAINT RELATED**
Less restrictive methods of behavior management considered:	
Restraint/Seclusion order date/time:	
Quote actual restraint or seclusion order(s)	
Was the restraint or seclusion ordered by: Physician___ Other Licensed Practitioner_____	
Were staff trained in the use of emergency safety interventions: Yes _____ No_____	
Was the resident's treatment team physician contacted (unless same as ordering physician)	
Yes_____ No_____ N/A - same as ordering physician__	
Was the resident evaluated immediately after restraint removed or removed from seclusion?	
Yes_____ No_____ NA	
Monitoring method(s), frequency, last date/time monitored:	
Last date/time of assessment:	
Additional Information/Comments: (**NOT RESTRAINT/SECLUSION RELATED)**	
Action Information	
Facility Information	
Other agencies the provider notified (SMA, DHS, SA, etc.):	
Agency/date/time:	
Agency/date/time:	
Agency/date/time:	
Agency/date/time:	
Agency/date/time:	
SA Action(s)	
Date of receipt of restraint/seclusion death report from PRTF: _____	
Date of Survey: _____	
RO Actions(s)	

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RESTRAINT or SECLUSION INFO	NOT RESTRAINT RELATED
Date of receipt of restraint/seclusion death report from PRTF: _____	
Date sent as a complaint to SA (if applicable) _____	
CO Audit(s)	
Date of receipt of initial restraint/seclusion death report from RO: _____	
Date of receipt of restraint/seclusion death report worksheet: _____	
Person recording the information: _____	

PRA Disclosure Statement

This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) with monitoring of deaths in psychiatric residential treatment facilities (PRTF) as well as the use of restraints and seclusion. This mandatory information collection (42 U.S.C. 1396a) will be used at an aggregate level to monitor the overall safety of children residing in PRTFs and the appropriate implementation of behavioral interventions and the safe use of restraint and seclusion, only as necessary. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The control number for this project is 0938-0833 (Expires: TBD). Public burden for all of the collection of information requirements under this control number is estimated to range from 5 minutes to 8 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.