Death Notification Form

Guidance Notes

Please complete this form within 48 hours of a death occurring in accordance with section 2A or as soon as possible and in any event within 7 days of a sudden unexplained death in accordance with section 2B.

The form should be completed in legible writing using a ballpoint pen in black ink. Please ensure that all fields are completed.

A copy of the form should be sent to the **Mental Health Information Officer, Standards and Quality Assurance Division, Mental Health Commission, St. Martin's House, Waterloo Road, Dublin 4. Phone: (01) 636 2400 Fax: (01) 636 2440.**

1.1	**Service user details**			
	First Name (Initials):		Surname (Initials):	
	Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)		PPS Number: ☐☐☐☐☐☐☐☐☐☐ (where available)	
	Home Address:			
	Legal Status: Voluntary ☐	Involuntary ☐	Ward of Court ☐	Non Applicable ☐
	Marital Status: Married ☐	Single ☐	Separated/Divorced ☐	Widowed ☐
1.2	**ICD 10 Diagnosis**			
	1.			
	2.			
1.3	**Medication prescribed proximate to time of death** (please use generic name)		**Dosage**	
2.1	**Name of Approved Centre/ Day Hospital/Day Centre/ 24 Hour Residence**			
2.2	**Address of service**			
2.3	**Name of Unit within above service**			
3.1	**Date on which Death Occurred** ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)			
3.2	**Certified Time of Death** ☐☐ : ☐☐ (24 hour clock e.g. 2.20pm is 14.20)			
3.3	**Known Circumstances surrounding Death**			
3.4	**Exact Location where the death occurred if known**			
4.1	**Who/what agencies have been notified of the death**			
4.2	**Review Planned** Yes ☐ No ☐		**Review Taken Place** Yes ☐ No ☐ N/A ☐	
	If yes to either/both, please elaborate:			
5.1	**Form Completed by**			
	Name:		Signature:	
	Job Title:			
	Date: ☐☐ / ☐☐ / ☐☐☐☐ (dd/mm/yyyy)		Time: ☐☐ : ☐☐ (24 hour clock e.g. 2.20pm is 14.20)	
5.2	Submission Date to MHC: ☐☐ ☐☐ ☐☐☐☐ (dd/mm/yyyy)			