

Old Death Notification Form - 1976

## ESRD DEATH NOTIFICATION

END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM

Form Approved  
OMB No. 68-R

1. PATIENT'S LAST NAME		FIRST	MI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S COUNTY OF RESIDENCE*		4. STATE	5. DATE OF BIRTH		6. DATE OF DEATH
		--	Mo.	Day	Yr.
		--	Mo.	Day	Yr.
7. PROVIDER NAME AND ADDRESS (CITY AND STATE)					
8. PROVIDER NUMBER		9. PLACE OF DEATH (Check one)		10. WAS AN AUTOPSY PERFORMED?	
		1 <input type="checkbox"/> Hospital		3 <input type="checkbox"/> Home	
		2 <input type="checkbox"/> Dialysis facility		4 <input type="checkbox"/> Other	
				1 <input type="checkbox"/> Yes	
				2 <input type="checkbox"/> No	
11. CAUSES OF DEATH (Place number from the List of Causes in the spaces provided).					
Primary Cause _____					
Secondary Causes _____					
LIST OF CAUSES					
01 Pericarditis (Including cardiac tamponade)		05 Embolism, air		10 Pulmonary infection	
02 Myocardial infarction, acute		06 Embolism, pulmonary		11 Septicemia	
03 Cardiac (Other than 01 or 02)		07 GI hemorrhage		12 Viral hepatitis	
04 Cerebrovascular (Including spontaneous subdural hematoma)		08 Vascular access hemorrhage		13 Infection (Other than 10, 11, or 12)	
		09 Hemorrhage (Other than 04, 07, or 08)		14 Hyperkalemia	
				15 Pancreatitis	
				16 Malignancy	
				17 Withdrawal from dialysis	
				18 Suicide	
				19 Accidental death, treatment related (Other than 05)	
				20 Accidental death not treatment related	
				21 Unknown cause	
				22 Other (Specify in Remarks)	
12. IF A MALIGNANCY WAS PRESENT AT DEATH, INDICATE THE YEAR DIAGNOSED, SITE AND TYPE OF EACH PRIMARY.					
1. _____		2. _____		3. _____	
Yr.		Site		Type	
_____		_____		_____	
Yr.		Site		Type	
_____		_____		_____	
13. IF DECEASED RECEIVED A TRANSPLANT			REMARKS		
1. Date of most recent transplant					
Mo.   Day   Yr.					
2. Was kidney functioning (Patient off dialysis) prior to death?					
1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No    3 <input type="checkbox"/> Unknown			SIGNATURE _____		
3. Did transplant patient resume outpatient chronic maintenance dialysis prior to death?					
1 <input type="checkbox"/> Yes    2 <input type="checkbox"/> No			DATE _____		

NOTE: \*If patient residence is not in a specific county, enter incorporated city or township.

Under provisions of the Privacy Act 1974, P.L. 93-579, amending Title 5, United States Code, the information collected herein is not being used for any purpose other than to accommodate the renal provisions of P.L. 92-603.