DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Form Approved: OMB Number 0930-0296 Expiration Date: 10/31/2011

CENTER FOR SUBSTANCE ABUSE TREATMENT	See OMB Statement on Reverse
SAMHSA OTP Mortality Report	Date of Report:// Follow-up report?
Note: This form will assist in the regulatory agency review of patients who die while enrolled in Opioid Treatment Programs certified to operate by SAMHSA. The goal is to improve the quality of care of these programs. Please print all information clearly.	
A. Background Information	
Patient's OTP ID No.:	Program OTP No.: (Same as SAMHSA ID)
Patient's Date of Birth:/(e.g., mm/dd/yyyy)	Patient's ZIP Code of Residence:
Patient's Sex: Female Male	Approximate Date of Death:/(e.g., mm/dd/yyyy)
Patient's Admission Date:/(e.g., mm/dd/yyyy)	Reporter's Name: (e.g., last, first)
B. Date and Amount of Last Opioid Dose Dispensed Before Death:	C. Treatment Objective at Time of Death:
Last Time Dosed at Clinic:/(e.g., mm/dd/yyyy)	InductionMaintenanceMedically Supervised
Opioid:Methadone orSuboxone orSubutex	Other Withdrawal (Detox)
Last Dose: mgs Please indicate if this is a split dose:	D. Most Recent Drug Test Date:/ (e.g., mm/dd/yyyy)
Number of Take-Home Doses Dispensed at Last Visit:	Positive Results:
•	- Solito Rosalio.
E. Medical and Psychiatric Diagnosis: (Provide ICD-9 codes)	F. Preliminary (P) or Confirmed (C) Underlying Cause/Mechanism of Death:
Axis I	P C P C
Axis II	Unknown/Undetermined Cardiovascular
Axis III	Overdose COPD
Axis IV	Motor Vehicle Accident Diabetes
Axis V	Other Type of Accident HIV/AIDS
For SUD:	Homicide Kidney Disease Suicide Liver Disease
☐ Early Remission ☐ Full Remission	Trauma Suicide Liver Disease Seizures
Partial Remission Controlled Environment	Cancer Other (list)
E Controlled Environment	
G. List of Known OTC and Prescription Medications at the Time of Last Visit:	
Medication Name Strength Dose/Amount Frequency	Medication Name Strength Dose/Amount Frequency
	
H. Description of Event (detailed description of the factors related to the patient's death, including where the death occurred, if others were involved, how the death was discovered, list of illicit drugs involved, etc.). If more space is needed, use a continuation sheet, as described in the general instructions accompanying this form.	
I. Other Relevant Medical History (for example, allergies, pregnancy, preexisting medical conditions):	
J. Medical Examiner's/Coroner's Contact Information (if known):	Please attach ME/Coroner's report or forward when available.
Please fax to CSAT/DPT at 240– 276–1630. Patient and reporter identifiers reported to SAMHSA on this form will be kept confidential by SAMHSA and will not be disseminated outside of the Federal Government except as required by law or otherwise authorized under 42 CFR Part 2.	

Purpose of Form: This form will assist in the regulatory agency review of patients who die while enrolled in Opioid Treatment Programs certified to operate by SAMHSA.

Paperwork Reduction Act Statement

Public Burden Statement: 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 OMB control number. The OMB control number for this project is 0930-0296. Public reporting burden for this collection of information is estimated to average .50 hours per client per year, 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 SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 7-1044, Rockville, Maryland 20857.

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