INSTRUCTIONS FOR FAX

SAMHSA OTP MORTALITY REPORT (FORM SMA-XXX)

Purpose of Form: The SMA-XXX form was created to assist in the regulatory agency review of mortality data on patients who, at the time of death, were enrolled in Opioid Treatment Program (OTPs) certified to operate by SAMHSA. Reporting by OTPs is voluntary. The form should be used to report the death of any patient who was enrolled in an OTP at the time of death, even if the underlying cause of death does not appear to be related to opioid addiction treatment.

Understanding the cause of death of patients enrolled in OTPs or other drug treatment facilities can be a challenging task for many reasons, including inconsistencies in how deaths are reported; patients' use of other drugs, including illicit, over-the-counter, and prescription products; and other aspects of the patient's physical and mental condition. The standardized terminology in this report will contribute to a more precise analysis of the data received. The data will be used to increase understanding of the factors contributing to these deaths and to help improve the quality of care.

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.

GENERAL INSTRUCTIONS

- It is preferred that the form be filled out by qualified medical personnel familiar with the patient's medical history and treatment at the OTP. If someone else fills out the form, qualified medical personnel should review the completed form prior to submission.
- Use a separate form for each patient. Complete **ALL** items on the form. If an item does not apply, type "N/A". If more information is received about a patient after the form has been submitted, use a new OTP Mortality Report form to submit follow-up information to SAMHSA. In this case, the reporter should type an X in the "follow-up form" box next to "Date of Report" in the upper right hand corner of the form.
- If more room is needed for any narrative entry, attach additional pages as needed. Identify all attached pages as *Page _____of _____*. Indicate the appropriate section and item letter next to the narrative continuation.
- If you complete this form by hand, **PLEASE PRINT LEGIBLY.**
- The instructions below show each lettered item from the form in **bold text**. The column next to the bold text describes the information requested.

SPECIFIC INSTRUCTIONS

ITEM	INSTRUCTIONS
A. Background Information	
Patient's OTP ID No.	This is the number assigned by the OTP to identify the patient. Do not use the patient's name or other identifying information (e.g., Social Security Number). The number of digits does **NOT** need to match the number of boxes on the form.
Program OTP No.	This is the Opioid Treatment Program (OTP) identification number (same as the old FDA number). Begin with the 2 letters of your State abbreviation, followed by 5 numbers, then a letter. This number should fit the format on the form.
Patient's Date of Birth	Enter the date of birth in the order of month, day, and year. For example 02/05/1960 = February 5, 1960.
Patient's ZIP Code of Residence	Enter the patient's five number home ZIP Code.
Patient's Sex	Enter the patient's gender by putting a check mark next to F for female, M for male.

ITEM	INSTRUCTIONS
A. Background Information (continued)	
Approximate Date of Death	Enter the date of death or if not available, provide the most precise information available. Enter the date in the order of month, day, and year. For example, 08/30/2007 = August 30, 2007.
Patient's Admission Date	Enter the patient's admission date to the OTP in the order of month, day, and year. For example, 06/10/2007 = June 10, 2007.
Reporter's Name (last, first)	**PRINT** the name of the person filling out this form. The order is last name, first name.
B. Date and Amount of Last Opioid Dispensed Before Death	Enter the date the patient was last medicated at the OTP in the order of month, day, and year. For example, 07/01/2007 = July 1, 2007. Enter a check mark or X next to the opioid dispensed. In the blank next to the words "Last Dose," enter the dosage amount.
Number of Take-Home Doses Dispensed at Last Visit	Enter how many daily doses of opioids were given to the patient to take home on the last known treatment date before death.
C. Treatment Objective at Time of Death	Check the treatment objective at time of death. If it is not listed on the form, check "Other" and type or print the treatment objective clearly on the line provided.
D. Most Recent Drug Test Date	Enter the date of the last drug test given before the patient's death. Enter the date in the order of month, day, and year. For example, 07/08/2007 = July 8, 2007.
Results	Indicate the results of the last drug test. Provide as much information as possible, and include both illicit and legal drugs found on the test.
E. Medical and Psychiatric Diagnosis	Indicate the patient's medical and psychiatric diagnosis in accordance with the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). For Substance Use Disorder (SUD), indicate the stage of remission and whether the patient was in a controlled environment.
F. Preliminary (P) or Confirmed (C) Underlying Cause/Mechanism of Death	Place either a "P" for preliminary or "C" for confirmed next to any of the causes/conditions listed that may have contributed to the patient's death. More than one cause/condition can be checked. If the cause of death is not known, check "Unknown/Undetermined." If the cause is not listed on the form, check "Other," and type or print clearly the cause of death on the lines provided.
G. List of Known OTC and Prescription Medications at the Time of Last Visit	List known over-the-counter (OTC) and prescription medications the patient was taking at the time of the last visit. Do not include the opioid you selected in Item B above.
H. Description of Event Give a 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.	Describe how the death took place, including a detailed description of what happened, if other people were present or involved, where the death occurred, how the death was discovered, and the names of any illicit drugs involved. Include any other relevant details, including official notes taken by a hospital or other facility, if available. If more pages are needed, attach additional pages, as described in the general instructions.
I. Other Relevant Medical History (for example allergies, pregnancy, preexisting medical conditions)	Describe any other aspects of the patient's medical history that may be relevant to the cause of the patient's death.
J. Medical Examiner's/Coroner's Contact Information (if known)	If the medical examiner/coroner is known, enter the name (last name, first name), address, phone number, e-mail, and any other relevant contact information.
Please fax to CSAT/DPT at 240–276–1630	When you have completed the form, fax it to the number provided.

Effect: This form will assist regulatory agency review of mortality data on patients who, at the time of death, were enrolled in Opioid Treatment Programs (OTPs) 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-xxxx. 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.