DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
CENTER FOR SUBSTANCE ABUSE TREATMENT

Form Approved: OMB Number 0930-XXXX
Expiration Date: XX/XX/XXXX
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: mm / dd / yyyy

Patient's ZIP Code of Residence: __________

Patient's Sex: Female ___ Male ___

Approximate Date of Death: mm / dd / yyyy

Patient's Admission Date: ______/______/______
mm dd yyyy

Reporter's Name: ___________________________________
last name, first name

B. Date and Amount of Last Opioid Dose Dispensed Before Death:

Last Time Dosed at Clinic: mm / dd / yyyy

Opioid: ___Methadone *or* ___Suboxone *or* ___Subutex

Last Dose: _____ mgs

Number of Take-Home Doses Dispensed at Last Visit: __________

C. Treatment Objective at Time of Death:

___Induction ___Maintenance ___Medically Supervised Withdrawal (Detox)
___Other ______________________

D. Most Recent Drug Test Date: mm / dd / yyyy

Results: ____

E. Medical and Psychiatric Diagnosis:

___Axis I
___Axis II
___Axis III
___Axis IV
___Axis V

For SUD:
☐ Early Remission
☐ Partial Remission
☐ Full Remission

☐ Controlled Environment

F. Preliminary (P) or Confirmed (C) Underlying Cause/Mechanism of Death:

___Overdose
___Motor Vehicle Accident
___Homicide
___Suicide
___HIV/AIDS
___Cancer
___Cardiovascular
___Diabetes
___Kidney Disease
___Liver Disease
___Seizures
___Unknown/Undetermined
___Trauma
___COPD
___Other (list)
____
____

G. List of Known OTC and Prescription Medications at the Time of Last Visit:

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 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.

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-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.