

Public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. 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. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Office, 6705 Rockledge Drive, MSC 7730, Bethesda, MD 20892-7730, ATTN: PRA (0925-0414). Do not return the completed form to this address.

-Affix label here-

Member ID: \_\_\_\_\_  
First Name \_\_\_\_\_ M.I. \_\_\_\_\_  
Last Name \_\_\_\_\_

Contact date: [ ][ ]-[ ][ ]-[ ][ ] (M/D/Y)

Completed by: [ ][ ]-[ ][ ]-[ ][ ]

Contact type: \_1 Phone \_2 Mail \_8 Other

1. What is the date of death? [ ][ ]-[ ][ ]-[ ][ ] (M/D/Y)

2. Source of notification: (Mark one.)

- \_1 Family member
- \_2 Friend/associate of deceased
- \_3 Personal physician
- \_4 NDI (CCC use only)
- \_8 Other \_\_\_\_\_

2.1. Name, address and phone number of the source.

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Provider ID

[ ][ ][ ][ ]

3. Did the death occur in a hospital/medical institution (i.e., hospital, long term care facility, hospice)?

- \_0 No
- \_1 Yes
- \_9 Unknown → Go to Page 2.

3.1. Name, address and phone number of the hospital/medical institution (i.e., hospital, long term care facility, hospice).

Hospital Name: \_\_\_\_\_

City/State: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Go to Page 2.

Provider ID

[ ][ ][ ][ ]

3.2. Location and address of death, if death did not occur in a hospital/medical institution.

Location: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

RV \_\_\_\_\_ K \_\_\_\_\_ V \_\_\_\_\_

4. Was an autopsy done?

- <sub>0</sub> No
- <sub>1</sub> Yes
- <sub>9</sub> Unknown

4.1. Name, address and phone number where autopsy was performed.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Provider ID  
 \_\_\_\_\_

5. Where will the death certificate be obtained?

- <sub>1</sub> Coroner/Medical Examiner
- <sub>2</sub> Personal physician
- <sub>3</sub> Vital Statistics Office
- <sub>8</sub> Other (*Specify*): \_\_\_\_\_
- <sub>9</sub> Unknown

5.1. Name, address and phone number of individual providing the death certificate.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Provider ID  
 \_\_\_\_\_

6. (Ask of source): To the best of your knowledge, what was the underlying cause of death?

\_\_\_\_\_

\_\_\_\_\_

7. On the basis of currently available data, what was the underlying cause of death? (Mark one.)

- | Cancer  | Cardiovascular Disease  | "Other" Cause of Death   |
|---|---|--|
| <input type="checkbox"/> <sub>1</sub> Breast                | <input type="checkbox"/> <sub>11</sub> Coronary Heart Disease (CHD)       | <input type="checkbox"/> <sub>31</sub> Alzheimer's Disease                 |
| <input type="checkbox"/> <sub>2</sub> Ovarian               | <input type="checkbox"/> <sub>12</sub> Cerebrovascular disease            | <input type="checkbox"/> <sub>32</sub> COPD                                |
| <input type="checkbox"/> <sub>3</sub> Endometrial           | <input type="checkbox"/> <sub>13</sub> Pulmonary Embolism                 | <input type="checkbox"/> <sub>33</sub> Pneumonia                           |
| <input type="checkbox"/> <sub>4</sub> Colon                 | <input type="checkbox"/> <sub>18</sub> Other cardiovascular disease _____ | <input type="checkbox"/> <sub>34</sub> Pulmonary Fibrosis                  |
| <input type="checkbox"/> <sub>5</sub> Rectosigmoid junction | <input type="checkbox"/> <sub>19</sub> Unknown cardiovascular disease     | <input type="checkbox"/> <sub>35</sub> Renal Failure                       |
| <input type="checkbox"/> <sub>6</sub> Rectum                |   | <input type="checkbox"/> <sub>36</sub> Sepsis                              |
| <input type="checkbox"/> <sub>7</sub> Uterus                | <b>Accident/Injury</b>  | <input type="checkbox"/> <sub>88</sub> Another cause of death, known _____ |
| <input type="checkbox"/> <sub>10</sub> Lung                 | <input type="checkbox"/> <sub>21</sub> Homicide                           | <input type="checkbox"/> <sub>99</sub> Unknown cause of death              |
| <input type="checkbox"/> <sub>8</sub> Other cancer _____    | <input type="checkbox"/> <sub>22</sub> Accident                           |  |
| <input type="checkbox"/> <sub>9</sub> Unknown cancer site   | <input type="checkbox"/> <sub>23</sub> Suicide                            |  |
|   | <input type="checkbox"/> <sub>28</sub> Other Injury _____                 |  |