

Disaster-related Mortality Surveillance Form .Complete one form per decedent

Complete the form for all known deaths related to a disaster: This information should be obtained from a medical examiner, coroner, hospital, funeral home or DMORT (Disaster Mortuary Team) office. Please, complete one form per decedent.

Form v1.1
Rev.03/21/2007

Part I General information

1. Type of disaster: <input type="checkbox"/> Hurricane (name _____) <input type="checkbox"/> Heat wave <input type="checkbox"/> Tornado <input type="checkbox"/> Technological disaster <input type="checkbox"/> Flood <input type="checkbox"/> Terrorism <input type="checkbox"/> Earthquake <input type="checkbox"/> Other (specify) _____		2. Facility type (info source): Please check one that best applies. <input type="checkbox"/> ME office <input type="checkbox"/> Funeral home <input type="checkbox"/> Nursing home <input type="checkbox"/> Coroner office <input type="checkbox"/> Hospital <input type="checkbox"/> DMORT office <input type="checkbox"/> Other (specify) _____	
3. Facility address: Street _____ County/parish _____ State _____ Z-code _____		4. Contact person (informant): Name _____ Phone number _____ Email Address _____	

Part II Deceased information

5. Case / medical record number: _____		6. Body identified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	
7. Date of Birth (MM/DD/YY) ____/____/____ <input type="checkbox"/> Unknown		8. Age in years: ____ <input type="checkbox"/> < 1 yr <input type="checkbox"/> Unknown	
9. Residential address of decedent: County/parish _____ City _____ State _____ Zip code ____		10. Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic <input type="checkbox"/> Unknown	
11. Race: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Other race			
12. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined		13. Date of Death: (MM/DD/YY) ____/____/____ <input type="checkbox"/> Unknown	
14. Time of Death: <input type="checkbox"/> ____ (24 hr clock) <input type="checkbox"/> Unknown		15. Date of body recovery: (MM/DD/YY) ____/____/____ <input type="checkbox"/> Unknown	
16. Time of body recovery: <input type="checkbox"/> ____ (24 hr clock) <input type="checkbox"/> Unknown		17. Place of death or body recovery: <input type="checkbox"/> Decedent's home <input type="checkbox"/> Evacuation Center/shelter <input type="checkbox"/> Vehicle <input type="checkbox"/> Hospital <input type="checkbox"/> Hotel /motel <input type="checkbox"/> Nursing Home / long term care facility <input type="checkbox"/> Hospice facility <input type="checkbox"/> Unknown <input type="checkbox"/> Street/Road <input type="checkbox"/> Prison or detention center <input type="checkbox"/> Other (specify) _____	
18. Location of death or body recovery: State ____ county/parish _____ Intersection _____		19. Prior to death, the individual was a: <input type="checkbox"/> Resident <input type="checkbox"/> Non-resident-intrastate <input type="checkbox"/> Unknown <input type="checkbox"/> Foreign <input type="checkbox"/> Non-resident-interstate <input type="checkbox"/> Other _____	
20. Was the individual paid or volunteer worker involved in disaster response? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		21. Body recovered by: <input type="checkbox"/> Law enforcement <input type="checkbox"/> Fire department <input type="checkbox"/> DMORT <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> EMS <input type="checkbox"/> Search and rescue <input type="checkbox"/> Family or individual <input type="checkbox"/> Unknown	

Part III Cause and Circumstance of death (check one that best applies)

22. Mechanism or cause of death— Injury <input type="checkbox"/> Drowning <input type="checkbox"/> Electrocution <input type="checkbox"/> Lightning <input type="checkbox"/> Motor Vehicle occupant/driver <input type="checkbox"/> Pedestrian/bicyclist struck by vehicle <input type="checkbox"/> Structural collapse <input type="checkbox"/> Fall <input type="checkbox"/> Cut/struck by object/tool <input type="checkbox"/> Poisoning/ toxic exposure: <input type="checkbox"/> CO exposure <input type="checkbox"/> Inhalation of other fumes/smoke, dust, gases <input type="checkbox"/> Ingestion of drug or substance <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Suffocation/asphyxia <input type="checkbox"/> Burns (flame or chemical) <input type="checkbox"/> Firearm/gunshot <input type="checkbox"/> Extreme heat (e.g., hyperthermia) <input type="checkbox"/> Extreme cold (e.g., hypothermia) <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown cause of injury		23. Cause of death— Illness <input type="checkbox"/> Neurological disorders <input type="checkbox"/> Meningitis/encephalitis <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Stroke (hemorrhagic or thrombotic) <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Respiratory failure <input type="checkbox"/> COPD <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Cardiovascular failure <input type="checkbox"/> ASCVD <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Renal failure <input type="checkbox"/> GI and endocrine <input type="checkbox"/> Bleeding <input type="checkbox"/> Hepatic failure <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Diabetes complication <input type="checkbox"/> Sepsis <input type="checkbox"/> Dehydration <input type="checkbox"/> Allergic reaction <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown cause of illness		24. Cause of death: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Pending <input type="checkbox"/> Unknown 25. Relationship of cause of death to disaster: <input type="checkbox"/> Direct <input type="checkbox"/> Possible <input type="checkbox"/> Indirect <input type="checkbox"/> Undetermined 26. Circumstance of death: (free text) <input type="checkbox"/> Accident <input type="checkbox"/> Pending <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined 28. Who signed the death certificate? <input type="checkbox"/> ME/coroner <input type="checkbox"/> Physician <input type="checkbox"/> Not signed 29. Date of report completed: (MM/DD/YY) ____/____/____	
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