OMB #0925-0414 Exp: 5/03

COMMENTS

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 OMV 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, 6701 Rockledge Drive, MSC 7730, Bethesda, MD 20892-7730, ATTN: PRA (0925-0414). Do not return the completed form to this address.

-Affix label here-

Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __

First Name ________________________M.I.______

Last Name _________________________________

1. Contact date: |__|__|-|__|__|-|__|__| (M/D/Y)
2. Completed by: |__|__|__|
3. Contact type:
   - ☐1 Phone ☐3 Visit
   - ☐2 Mail ☐8 Other

4. Visit type:
   - ☐2 Semi-Annual #|__|__|
   - ☐3 Annual #|__|__|
   - ☐4 Non-Routine

5. What is the date of death? |__|__| - |__|__| - |__|__| (M/D/Y)
6. Source of notification: ***(Mark one.)***
   - ☐1 Family member
   - ☐2 Friend/associate of deceased
   - ☐3 Personal physician
   - ☐8 Other

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

Name: ______________________________

Address: ______________________________

____

Phone Number: (____) ______________________________

Provider ID |__|__|__|__|

7. Did the death occur in a medical institution (i.e., hospital, long term care facility, hospice)?
   - ☐0 No ☐1 Yes ☐9 Unknown

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

Hospital Name: ______________________________

City/State: ______________________________

Phone Number: (____) ______________________________

Provider ID |__|__|__|__|

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

Location: ______________________________

Address: ______________________________

____

RV___________KE_____________

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9. Was an autopsy done?

☐ 0 No ☐ 1 Yes ↓ ☐ 9 Unknown

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

Provider ID

Name: ____________________

Address: ____________________

____

Phone Number: (____) ____________________

10. Where was the death certificate obtained?

☐ 1 Coroner/Medical Examiner
☐ 2 Personal physician
☐ 3 Vital Statistics Office
☐ 8 Other ***(Specify):*** ____________________
☐ 9 Unknown

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

Provider ID

Name: ____________________

Address: ____________________

____

Phone Number: (____) ____________________

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

____

____

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

Cancer

☐ 1 Breast
☐ 2 Ovarian
☐ 3 Endometrial
☐ 4 Colon
☐ 5 Rectosigmoid junction
☐ 6 Rectum
☐ 7 Uterus
☐ 8 Other cancer ____________________
☐ 9 Unknown cancer site

Cardiovascular Disease

☐ 11 Coronary Heart Disease (CHD)
☐ 12 Cerebrovascular disease
☐ 13 Pulmonary Embolism
☐ 18 Other cardiovascular disease ____________________
☐ 19 Unknown cardiovascular disease

Accident/Injury

☐ 21 Homicide
☐ 22 Accident
☐ 23 Suicide
☐ 28 Other Injury ____________________

"Other" Cause of Death

☐ 88 Other cause of death, known ____________________
☐ 99 Unknown cause of death