Family Medicine Inpatient Service
Mortality Review and Report

Date of Event	
Attending Physician of Record	
Resident Physician Completing Form	
MRN	

1) Age of patient: 2) Cause of death as listed on post mortem form completed by resident: (see reverse) 2a) Cause of death as listed on death certificate completed by attending?		
3) Was death expected?	☐ Yes	☐ No
4) Was autopsy considered?	☐ Yes	☐ No
5a) Any potential problems with care identified?	☐ Yes	☐ No
5b) If Yes, briefly describe:		
6a) Were circumstances of death discussed? (e.g., discussed with team, M&M rounds, etc.)	☐ Yes	☐ No
6b) If yes, briefly describe:		
7) Date PCP notified:		

Attending Signature: ______________________________ **Date:** __________

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