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:
- ☐ Hurricane (name_____)
- ☐ Heat wave
- ☐ Tornado
- ☐ Technological disaster
- ☐ Flood
- ☐ Terrorism
- ☐ Earthquake
- ☐ Other (specify)_____

2. Facility type (info source): Please check one that best applies.
- ☐ ME office
- ☐ Funeral home
- ☐ Nursing home
- ☐ Coroner office
- ☐ Hospital
- ☐ DMORT office
- ☐ 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? ☐ Yes ☐ No ☐ Pending

7. Date of Birth (MM/DD/YY) ___ /___/____ ☐ Unknown

8. Age in years:_____☐ < 1 yr ☐ Unknown

9. Residential address of decedent:
County/parish_____ City_____
State_____ Zip code___

10. Ethnicity:
- ☐ Hispanic
- ☐ Non Hispanic
- ☐ Unknown

11. Race:
- ☐ American Indian or Alaskan Native
- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other race

12. Gender:
☐ Male ☐ Female
☐ Undetermined

13. Date of Death:
(MM/DD/YY) ____ /____/_____
☐ Unknown

14. Time of Death:
☐ _____(24 hr clock)
☐ Unknown

15. Date of body recovery:
(MM/DD/YY)
____/____/_____ ☐ Unknown

16. Time of body recovery:
☐ _____ (24 hr clock)
☐ Unknown

17. Place of death or body recovery:
- ☐ Decedent's home
- ☐ Evacuation Center/shelter
- ☐ Vehicle
- ☐ Hospital
- ☐ Hotel /motel
- ☐ Nursing Home / long term care facility
- ☐ Hospice facility
- ☐ Unknown
- ☐ Street/Road
- ☐ Prison or detention center
- ☐ Other (specify)_____

18. Location of death or body recovery:
State_____ county/parish_____
Intersection_____

19. Prior to death, the individual was a:
- ☐ Resident
- ☐ Non-resident-intrastate
- ☐ Unknown
- ☐ Foreign
- ☐ Non-resident-interstate
- ☐ Other_____

20. Was the individual paid or volunteer worker involved in disaster response?
☐ Yes ☐ No ☐Unknown

21. Body recovered by:
- ☐ Law enforcement
- ☐ Fire department
- ☐ DMORT
- ☐ Other (specify)_____
- ☐ EMS
- ☐ Search and rescue
- ☐ Family or individual
- ☐ Unknown

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

22. Mechanism or cause of death— Injury
- ☐ Drowning
- ☐ Electrocution
- ☐ Lightning
- ☐ Motor Vehicle occupant/driver
- ☐ Pedestrian/bicyclist struck by vehicle
- ☐ Structural collapse
- ☐ Fall
- ☐ Cut/struck by object/tool
- ☐ Poisoning/ toxic exposure:
  - ☐ CO exposure
  - ☐ Inhalation of other fumes/smoke, dust, gases
  - ☐ Ingestion of drug or substance
  - ☐ Other (specify)_____
- ☐ Suffocation/asphyxia
- ☐ Burns (flame or chemical)
- ☐ Firearm/gunshot
- ☐ Extreme heat (e.g., hyperthermia)
- ☐ Extreme cold (e.g., hypothermia)
- ☐ Other (specify)_____
- ☐ Unknown cause of injury

23. Cause of death— Illness
- ☐ Neurological disorders
  - ☐ Meningitis/encephalitis
  - ☐ Seizure disorder
  - ☐ Stroke (hemorrhagic or thrombotic)
  - ☐ Other (specify)_____
- ☐ Respiratory failure
  - ☐ COPD
  - ☐ Pneumonia
  - ☐ Asthma
  - ☐ Pulmonary embolism
  - ☐ Other (specify)_____
- ☐ Cardiovascular failure
  - ☐ ASCVD
  - ☐ Congestive heart failure
  - ☐ Other (specify)_____
- ☐ Renal failure
- ☐ GI and endocrine
  - ☐ Bleeding
  - ☐ Hepatic failure
  - ☐ Pancreatitis
  - ☐ Diabetes complication
- ☐ Sepsis
- ☐ Dehydration
- ☐ Allergic reaction
- ☐ Other (specify)_____
- ☐ Unknown cause of illness

24. Cause of death:
- ☐ Confirmed
- ☐ Probable
- ☐ Pending
- ☐ Unknown

25. Relationship of cause of death to disaster:
- ☐ **Direct**
- ☐ **Possible**
- ☐ **Indirect**
- ☐ **Undetermined**

26. Circumstance of death: (free text)

27. Manner/intent of death:
- ☐ Natural
- ☐ Suicide
- ☐ Accident
- ☐ Pending
- ☐ Homicide
- ☐ Undetermined

28. Who signed the death certificate?
- ☐ ME/coroner
- ☐ Physician
- ☐ Not signed

29. Date of report completed:
(MM/DD/YY) ___/____/_____