

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 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, 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 _____

9. Was an autopsy done?

- ₀ No
 - ₁ Yes
 - ₉ Unknown
- ↓

<p>9.1. Name, address and phone number where autopsy was performed.</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone Number: (____) _____</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center; padding: 2px;">Provider ID</td></tr> <tr><td style="text-align: center; padding: 2px;"> _ _ _ _ </td></tr> </table>	Provider ID	_ _ _ _
Provider ID			
_ _ _ _			

10. Where was the death certificate obtained?

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

<p>10.1. Name, address and phone number of individual providing the death certificate.</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone Number: (____) _____</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="text-align: center; padding: 2px;">Provider ID</td></tr> <tr><td style="text-align: center; padding: 2px;"> _ _ _ _ </td></tr> </table>	Provider ID	_ _ _ _
Provider ID			
_ _ _ _			

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 | Cardiovascular Disease | Accident/Injury |
|---|---|--|
| <input type="checkbox"/> ₁ Breast | <input type="checkbox"/> ₁₁ Coronary Heart Disease (CHD) | <input type="checkbox"/> ₂₁ Homicide |
| <input type="checkbox"/> ₂ Ovarian | <input type="checkbox"/> ₁₂ Cerebrovascular disease | <input type="checkbox"/> ₂₂ Accident |
| <input type="checkbox"/> ₃ Endometrial | <input type="checkbox"/> ₁₃ Pulmonary Embolism | <input type="checkbox"/> ₂₃ Suicide |
| <input type="checkbox"/> ₄ Colon | <input type="checkbox"/> ₁₈ Other cardiovascular disease | <input type="checkbox"/> ₂₈ Other Injury _____ |
| <input type="checkbox"/> ₅ Rectosigmoid junction | _____ | |
| <input type="checkbox"/> ₆ Rectum | <input type="checkbox"/> ₁₉ Unknown cardiovascular disease | |
| <input type="checkbox"/> ₇ Uterus | | “Other” Cause of Death |
| <input type="checkbox"/> ₈ Other cancer _____ | | <input type="checkbox"/> ₈₈ Other cause of death, known |
| <input type="checkbox"/> ₉ Unknown cancer site | | _____ |
| | | <input type="checkbox"/> ₉₉ Unknown cause of death |

