

ESRD DEATH NOTIFICATION

END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM

1. Patient's Last Name	First	MI	2. Medicare Claim Number
3. Patient's Sex a. <input type="checkbox"/> Male b. <input type="checkbox"/> Female	4. Date of Birth ____ / ____ / ____ Month Day Year		5. Social Security Number
6. Patient's State of Residence	7. Place of Death a. <input type="checkbox"/> Hospital c. <input type="checkbox"/> Home e. <input type="checkbox"/> Other b. <input type="checkbox"/> Dialysis Unit d. <input type="checkbox"/> Nursing Home		8. Date of Death ____ / ____ / ____ Month Day Year
9. Modality at Time of Death a. <input type="checkbox"/> Incenter Hemodialysis b. <input type="checkbox"/> Home Hemodialysis c. <input type="checkbox"/> CAPD d. <input type="checkbox"/> CCPD e. <input type="checkbox"/> Transplant f. <input type="checkbox"/> Other			
10. Provider Name and Address (Street)			11. Provider Number

Provider Address (City/State)

12. Causes of Death (enter codes from list on back of form)

a. Primary Cause _ _ _

b. Were there secondary causes?

No

Yes, specify: _ _ _ _ _ _ _ _ _ _ _ _

c. If cause is other (98) please specify: _____

<p>13. Renal replacement therapy discontinued prior to death: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, check one of the following:</p> <p>a. <input type="checkbox"/> Following HD and/or PD access failure</p> <p>b. <input type="checkbox"/> Following transplant failure</p> <p>c. <input type="checkbox"/> Following chronic failure to thrive</p> <p>d. <input type="checkbox"/> Following acute medical complication</p> <p>e. <input type="checkbox"/> Other</p> <p>f. Date of last dialysis treatment ____ / ____ / ____ Month Day Year</p>	<p>14. Was discontinuation of renal replacement therapy after patient/family request to stop dialysis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown <input type="checkbox"/> Not Applicable</p>
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<p>15. If deceased ever received a transplant:</p> <p>a. Date of most recent transplant ____ / ____ / ____ <input type="checkbox"/> Unknown Month Day Year</p> <p>b. Type of transplant received <input type="checkbox"/> Living Related <input type="checkbox"/> Living Unrelated <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown</p> <p>c. Was graft functioning (patient not on dialysis) at time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>d. Did transplant patient resume chronic maintenance dialysis prior to death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>16. Was patient receiving Hospice care prior to death?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>
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17. Name of Physician (Please print complete name)	18. Signature of Person Completing This Form	Date
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This report is required by law (42, U.S.C. 426; 20 CFR 405, Section 2133). Individually identifiable patient information will not be disclosed except as provided for in the Privacy Act of 1974 (5 U.S.C. 5520; 45 CFR Part 5a).

ESRD DEATH NOTIFICATION FORM

LIST OF CAUSES

CARDIAC

- 23 Myocardial infarction, acute
- 25 Pericarditis, incl. Cardiac tamponade
- 26 Atherosclerotic heart disease
- 27 Cardiomyopathy
- 28 Cardiac arrhythmia
- 29 Cardiac arrest, cause unknown
- 30 Valvular heart disease
- 31 Pulmonary edema due to exogenous fluid
- 32 Congestive Heart Failure

VASCULAR

- 35 Pulmonary embolus
- 36 Cerebrovascular accident including intracranial hemorrhage
- 37 Ischemic brain damage/Anoxic encephalopathy
- 38 Hemorrhage from transplant site
- 39 Hemorrhage from vascular access
- 40 Hemorrhage from dialysis circuit
- 41 Hemorrhage from ruptured vascular aneurysm
- 42 Hemorrhage from surgery (not 38, 39, or 41)
- 43 Other hemorrhage (not 38-42, 72)
- 44 Mesenteric infarction/ischemic bowel

INFECTION

- 33 Septicemia due to internal vascular access
- 34 Septicemia due to vascular access catheter
- 45 Peritoneal access infectious complication, bacterial
- 46 Peritoneal access infectious complication, fungal
- 47 Peritonitis (complication of peritoneal dialysis)
- 48 Central nervous system infection (brain abscess, meningitis, encephalitis, etc.)
- 51 Septicemia due to peripheral vascular disease, gangrene
- 52 Septicemia, other
- 61 Cardiac infection (endocarditis)
- 62 Pulmonary infection (pneumonia, influenza)
- 63 Abdominal infection (peritonitis (not comp of PD), perforated bowel, diverticular disease, gallbladder)
- 70 Genito-urinary infection (urinary tract infection, pyelonephritis, renal abscess)

LIVER DISEASE

- 64 Hepatitis B
- 71 Hepatitis C
- 65 Other viral hepatitis
- 66 Liver-drug toxicity
- 67 Cirrhosis
- 68 Polycystic liver disease
- 69 Liver failure, cause unknown or other

GASTRO-INTESTINAL

- 72 Gastro-intestinal hemorrhage
- 73 Pancreatitis
- 75 Perforation of peptic ulcer
- 76 Perforation of bowel (not 75)

METABOLIC

- 24 Hyperkalemia
- 77 Hypokalemia
- 78 Hyponatremia
- 79 Hyponatremia
- 100 Hypoglycemia
- 101 Hyperglycemia
- 102 Diabetic coma
- 95 Acidosis

ENDOCRINE

- 96 Adrenal insufficiency
- 97 Hypothyroidism
- 103 Hyperthyroidism

OTHER

- 80 Bone marrow depression
- 81 Cachexia/failure to thrive
- 82 Malignant disease, patient ever on Immunosuppressive therapy
- 83 Malignant disease (not 82)
- 84 Dementia, incl. dialysis dementia, Alzheimer's
- 85 Seizures
- 87 Chronic obstructive lung disease (COPD)
- 88 Complications of surgery
- 89 Air embolism
- 104 Withdrawal from dialysis/uremia
- 90 Accident related to treatment
- 91 Accident unrelated to treatment
- 92 Suicide
- 93 Drug overdose (street drugs)
- 94 Drug overdose (not 92 or 93)
- 98 Other cause of death
- 99 Unknown

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0448. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.
