Georgia Department of Public Health

Brenda Fitzgerald, MD, Commissioner | Nathan Deal, Governor

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***CONFIDENTIAL***

# Pediatric Asthma Mortality Report

***This form should be completed for the death of a child who has been diagnosed with asthma or whose cause of death was related to asthma. Medical examiners, coroners and persons who report deaths or sign death certificates should report pediatric asthma deaths to the Department of Public Health, Chronic Disease Prevention Section within 7 days of a pediatric asthma death occurrence. Complete this form in its entirety and attach a copy of the case records. If submitting information from a non-medical facility, omit the clinical section (pages 2 -3).***

***Fax forms to 404-463-8954.***

**DEATH CERTIFICATE NUMBER** _____ **HOSPITAL CHART NUMBER** _____

**DEMOGRAPHICS OF THE DECEASED**

Name _____ Date of Birth _____

Race (check all that apply)

□ White or Caucasian
□ Black or African American
□ Asian
□ American Indian and Alaskan Native
□ Native Hawaiian or Pacific Islander
□ Multiracial
□ Other; please specify _____
□ Unknown

Ethnicity

□ Hispanic or Latino
□ Not Hispanic or Latino
□ Unknown

Deceased Address
(Street, City, State, Zip code) _____

Residence County _____ Residence State (if not GA) _____

Name and location of school
(Street, City, State, Zip code) _____

**CIRCUMSTANCES PRECEDING DEATH (acute presentation)**

Name of adult witnessing start of asthma episode:

Start of asthma symptoms: (Date) (Time)

Place asthma symptoms began

| | |
|---|---|
| ☐ Home or residence | ☐ School |
| ☐ Other; please specify:_____ | ☐ Not documented |

Known or suspected exposures 24 hours prior to death

| | | | |
|---|---|---|---|
| ☐ Upper respiratory infection | ☐ Exercise | ☐ Pollen | ☐ Pets (Animal dander) |
| ☐ Smoke | ☐ Stress | ☐ Other _____ | ☐ Not documented |

**LOCALITY WHERE DEATH OCCURRED**

Place of Death

| | |
|---|---|
| ☐ Home of residence | ☐ Ambulance during EMS transport |
| ☐ Emergency Room | ☐ Other; please specify _____ |
| ☐ Hospital | ☐ Unknown |

County State (if not GA)

**CLINICAL INFORMATION**

ADMISSION AT INSTITUTION WHERE DEATH OCCURRED OR WHERE IT WAS REPORTED

Date of admission Time of admission

Date of death Time of death

Status on admission (check all that apply)

| | | | |
|---|---|---|---|
| ☐ Unconscious | ☐ Airway obstruction | ☐ Respiratory distress | ☐ Respiratory arrest |
| ☐ Cardiac arrest | ☐ Allergic reaction | ☐ Seizures | ☐ Other; please specify |

Condition on admission

| | |
|---|---|
| ☐ Stable | ☐ Dead on arrival |
| ☐ Critically ill | ☐ Other; please specify _____ |

Signs and symptoms

| | | | | |
|---|---|---|---|---|
| ☐ Cyanotic | ☐ Respiratory distress | ☐ Vomiting | ☐ Wheezing | ☐ Cough |
| ☐ Retractions | ☐ Abnormal breath sounds | ☐ Other; please specify _____ | ☐ Asymptomatic | ☐ Not documented |

Viral Samples/labs (to be completed later, once results are available)

| Lab | Result |
|---|---|
| | |
| | |
| | |

**Interventions**

| Prior to arrival | | EMS | |
|---|---|---|---|
| □ Albuterol | □ Levalbuterol | □ Intubation | □ CPR |
| □ Epi-pen | □ AED | □ Defibrillation | □ Chest tube |
| □ CPR | □ Inhaled corticosteroid | □ Oxygen | □ Albuterol |
| □ Leukotriene Inhibitor | □ Mast cell inhibitor | □ Levalbuterol | □ Atropine |
| | | □ Epinephrine | □ Na Bicarb |
| □ OTC medication | □ Other | □ Other; please specify_____ | |

Emergency Department

| | |
|---|---|
| □ Intubation | □ Mechanical ventilation |
| □ Bilevel ventilation | □ CPR |
| □ Defibrillation | □ Oxygen |
| □ Chest tube | □ Other; please specify |

**REPORTED PATIENT HISTORY**

Asthma medications prescribed in the past 12 months

| Type | Number | Last date used |
|---|---|---|
| Reliever (i.e.: Albuterol) | | □ Today □ Past 7 days □ Past 30 days |
| Controller (i.e.: Inhaled corticosteroids) | | □ Today □ Past 7 days □ Past 30 days |

Known Allergies (check all that apply)

| | | |
|---|---|---|
| □ Food | □ Pets | □ Insects |
| □ Environmental | □ Unknown | |

Allergy history

| Allergy | Date noted | Type of test | Class/Severity | Anaphylaxis? | Epi pen? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

Number of previous anaphylaxis episodes: _____

History of comorbid conditions (check all that apply)

| | | | | |
|---|---|---|---|---|
| □ Prematurity | □ Cardiac disease | □ Chronic lung disease of prematurity | □ Allergic rhinitis/sinusitis | □ GERD |
| □ Obesity | □ Sleep apnea | □ Aspirin/NSAID sensitivity | □ Eczema | □ Other; please specify _____ |

Smoke exposure (check all that apply)

| | | |
|---|---|---|
| □ Tobacco smoking<br>□ Past 7 days □ Past 30 days | □ Living with tobacco smoker<br>□ Past 7 days □ Past 30 days | □ Tobacco smoke exposure in car or home other than primary residence<br>□ Past 7 days □ Past 30 days |
| □ Current use of wood stove or fireplace<br>□ Past 7 days □ Past 30 days | □ Forest or brush fire smoke exposure<br>□ Past 7 days □ Past 30 days | □ No smoke exposure<br>□ Past 7 days □ Past 30 days |

Medical/Psychological/Behavioral History

| Type | Number of visits (past 2 months) | Chief complaint | Interventions | Diagnosis |
|---|---|---|---|---|
| Primary care | | | □ Hospitalized<br>□ None<br>□ Not documented | □ Asthma<br>□ ADHD<br>□ Depression<br>□ Anxiety disorder<br>□ Other |
| Specialist | | | □ Hospitalized<br>□ None<br>□ Not documented | □ Asthma<br>□ ADHD<br>□ Depression<br>□ Anxiety disorder<br>□ Other |
| Hospitalization | | | □ PICU<br>□ Intubated<br>□ Other | □ Asthma<br>□ ADHD<br>□ Depression<br>□ Anxiety disorder<br>□ Other |
| ED visit | | | □ PICU<br>□ Intubated<br>□ Other | □ Asthma<br>□ ADHD<br>□ Depression<br>□ Anxiety disorder<br>□ Other |

**END OF REPORTED PATIENT HISTORY**

Autopsy performed? □ Yes □ No

*If yes, please report gross findings and send the detailed report later*

**CASE SUMMARY**

Please provide a short summary of the events surrounding the death.

**THIS FORM COMPLETED BY**

Name | Title

Office/Department

Case number (if assigned by reporting office)

Telephone | Fax

Date | Signature