GEORGIA DEPARTMENT OF PUBLIC HEALTH

Kathleen E. Toomey, M.D., M.P.H., Commissioner / Brian Kemp, Governor

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Confidential

Pediatric Asthma Mortality Report

This form must 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 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 1-404-738-2327 (NOTE: Please include the 1 prior to 404)

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

DEMOGRAPHICS OF THE DECEASED

Name _____ Date of Birth _____

Race (check all that apply)

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

Ethnicity

□ Hispanic or Latino	□ Unknown
□ Not Hispanic or Latino	

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 of 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 or 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
Relieve (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 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 □ Past 7 days □ Past 30 days	□ Living with tobacco smoker □ Past 7 days □ Past 30 days	□ Tobacco smoke exposure in car or home other than primary residence □ Past 7 days □ Past 30 days
Current use of wood stove or fireplace □ Past 7 days □ Past 30 days	Forest or brush fire smoke exposure □ Past 7 days □ Past 30 days	□ No exposure □ Past 7 days □ Past 30 days

Medical/Psychological/Behavioral History

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

END OF REPORTED HISTORY

Autopsy performed? ☐ Yes ☐ No

If yes, please report the 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