



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)

<input type="checkbox"/> White or Caucasian	<input type="checkbox"/> Native Hawaiian or Pacific Islander
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Multiracial
<input type="checkbox"/> Asian	<input type="checkbox"/> Other; please specify _____
<input type="checkbox"/> American Indian and Alaskan Native	<input type="checkbox"/> Unknown

Ethnicity

<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Unknown
<input type="checkbox"/> 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 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

History of comorbid conditions (check all that apply)

<input type="checkbox"/> Prematurity	<input type="checkbox"/> Cardiac disease	<input type="checkbox"/> Chronic lung disease of prematurity	<input type="checkbox"/> Allergic rhinitis/sinusitis	<input type="checkbox"/> GERD
<input type="checkbox"/> Obesity	<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Aspirin/NSAID sensitivity	<input type="checkbox"/> Eczema	<input type="checkbox"/> Other; please specify _____

Smoke exposure (check all that apply)

<input type="checkbox"/> Tobacco smoking <input type="checkbox"/> Past 7 days <input type="checkbox"/> Past 30 days	<input type="checkbox"/> Living with tobacco smoker <input type="checkbox"/> Past 7 days <input type="checkbox"/> Past 30 days	<input type="checkbox"/> Tobacco smoke exposure in car or home other than primary residence <input type="checkbox"/> Past 7 days <input type="checkbox"/> Past 30 days
<input type="checkbox"/> Current use of wood stove or fireplace <input type="checkbox"/> Past 7 days <input type="checkbox"/> Past 30 days	<input type="checkbox"/> Forest or brush fire smoke exposure <input type="checkbox"/> Past 7 days <input type="checkbox"/> Past 30 days	<input type="checkbox"/> No smoke exposure <input type="checkbox"/> Past 7 days <input type="checkbox"/> Past 30 days

Medical/Psychological/Behavioral History

Type	Number of visits (past 2 months)	Chief complaint	Interventions	Diagnosis
Primary care			<input type="checkbox"/> Hospitalized <input type="checkbox"/> None <input type="checkbox"/> Not documented	<input type="checkbox"/> Asthma <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Other
Specialist			<input type="checkbox"/> Hospitalized <input type="checkbox"/> None <input type="checkbox"/> Not documented	<input type="checkbox"/> Asthma <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Other
Hospitalization			<input type="checkbox"/> PICU <input type="checkbox"/> Intubated <input type="checkbox"/> Other	<input type="checkbox"/> Asthma <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Other
ED visit			<input type="checkbox"/> PICU <input type="checkbox"/> Intubated <input type="checkbox"/> Other	<input type="checkbox"/> Asthma <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> 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