REPORT ON DEATH DUE TO LEPTOSPIROSIS

INSTITUTIONAL DEATH REVIEW

To be completed by the Specialist or the Senior Medical Officer who attended the patient Name of the hospital: Ward No: BHT No: Part I: Basic Information of the Patient 1) Name: 2) Age: 3) Sex: 4) Address: **Part II: Admission details** 7) Date and time of admission to the hospital ММ D D Time 8) Whether transferred? Yes \square No \square 9) If yes, from which hospital? 10) Whether the BHT stamped 'urgent'? Yes ☐ Ward ETU 11) Place of admission: 12) Time of admission to ward/ETU: 13) Time of examination by the Medical Officer: **Part II: History** 14) Date of onset of symptoms MM DD 15) Where did the patient first seek medical advice? Government Hospital Name: Private Hospital **General Practitioner** Others (Specify)

16) Was patient admitted to a hospital after he first sought advice?			
17) Date of first hospital adm]□/□□ M D D	
18) History of any chronic dise	eases:		
Part IV: Details of clinical examination			
19) On admission, did the patient have any symptoms/signs suggestive of hepatic and/or renal impairment, cardiac failure and/or meningeal irritation? Yes No			
If 'yes', provide details:			
20) At the time of death, did the patient have any symptoms/signs suggestive of hepatic and/or renal impairment, cardiac failure and/or meningeal irritation? Yes No			
If 'yes', provide details:			
Part V: Details of clnical mana	<u>gement</u>		
21) Briefly give the details of medical treatment given:			
22) Comments on other aspect	ts of management		
Maintenance of	Satisfactory	Unsatisfactory	
Temperature chart			
Fluid balance chart Chart of vital signs			
51 TICAL 315113		<u> </u>	

Part VI: Details of laboratory investigation

23) Please furnish the results of following investigations (if available):

Investigation	Date & Results		
Full blood count			
Urine full report / proteinuria			
Blood Urea / creatinine			
SGPT / SGOT			
Direct microscopy			
SGPT / SGOT			
ECG			
MAT (Serology) (1 st & 2 nd)			
PCR			
Any other			
Part VII: Cause of death 24) Date and time of death Time:			
VV MM D	D		
YY MM DD			
25) Probable cause of death:			
Due to (if any)			
26) Co-morbidity conditions that might have contributed:			
27) Autopsy findings:			
28) Brief statement of events leading to death:			

29) View of the Specialist Medical Office on factors contributing to the death (*This question should only be answered by the Specialist Medical Officer in-Charge of the particular unit*)

Mark (v) where relevant.

Delay in seeking treatment by the patient	
Delay in transferring patient (if it was a transferred case)	
Lack of or non-availability of services (laboratory, transfusion etc.)	
Shortcomings in the clinical management (delayed diagnosis etc.)	
Any other factors identified (specify)	

identified:	ed to be taken to overcome the deficiencies
Name / Designation:	
Signature:	D ate:
Observations of the head of institution:	
	Date:
(Signature)	
Name:	
Designation:	
Institution	

Please fill this form and send to

Chief Epidemiologist
Epidemiology Unit
231, De Saram Place, Colombo 10
Tolonbono: 011 3605113, 011 3681541

Telephone: 011 2695112, 011 2681548 Fax: 011 2696583

A photo copy of the form to be kept in the institution