

**CONFIDENTIAL**

**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS  
PEER REVIEW OF DEATH REPORT FORM**

Individual's Name: \_\_\_\_\_ Age: \_\_  
\_\_\_\_\_

Facility: \_\_\_\_\_ Unit: \_\_\_\_\_ Date of Death: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. Cause of Death: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Does information in record support this diagnosis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Was appropriate medical care rendered to the individual regarding the conditions leading to death: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(a) If yes, was it complete and appropriate including referral, lab work, x-ray or consultations if indicated: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_

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(b) If not, what care should have been rendered: \_\_\_\_\_

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4. What other chronic or recent acute health problems contributed to this individual's death: \_\_\_\_\_

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5. Additional comments or suggestions: \_\_\_\_\_

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6. The following documents were reviewed (please check):

Death Certificate ( )      Autopsy ( )      Medical Records ( )

Other (specify): \_\_\_\_\_

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Signature of Reviewing Physician: \_\_\_\_\_

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***DISTRIBUTION:*** Original and allied documents will be sent to the facility administrator/executive director and the facility medical director for review/comment. Then, the medical director will forward the original peer review and allied documents to the

*department's director of quality assurance at the central office for his/her review/action. The peer review and allied documents will be maintained by the director of quality assurance, **not** at the facility or in the individual's file/chart, see directive [505-02-DD](#).*

SAMPLE