Dept of Surgery M&M Documentation – Mortality

ONE FORM TO BE COMPLETED BY HAND FOR EVERY PATIENT WHO DIES

DATE OF MEETING:

Patient's Hospital Number		**Patient's Initials**	
Patient's Age at death			
Dates of stay (admission to death)			
Admission Method (Circle)	A&E / Direct GP / Elective / Other (state)		
Consultant responsible for care			

The Patient	**Comments (brief)**		
Main diagnosis on admission			
Confirmed main diagnosis (after tests etc)			
Cause of death (taking all information into account including PM) **1a** **1b** **1c** **II**		**Avoidable Death?**	
Did the patient have a palliative care Dx?		**Hospital PM Done?**	
Was the Coroner informed?		**Was there a Coroner's Post mortem?**	
If malignancy was present, was it (circle please)	primary only, nodal mets, distant mets		
Were there any significant co-existing factors: cross out those that do not apply or state 'NONE'	Cardiovascular, Respiratory, Renal, Hepatic, Neurological/psychiatric, Advanced malignancy, Obstructive jaundice, Obesity, Diabetes OTHER:		

Operation Details			
What was the operation?			
Date of operation		**Time of operation**	
Was a pre-operative risk assessment performed?		**What was the predicted mortality pre-op?** (please calculate this if it was not done – www.riskprediction.org.uk)	
Mode of Surgery	Elective/Urgent/Emergency	**Surgical Approach**	Lap / Open
Consultant surgeon directly involved?		**Consultant anaesthetist directly involved?**	
ASA Grade	I / II / III / IV / V	**Did the patient return to theatre?**	Planned / Unplanned **Date:**
Was there an inadvertent injury to an organ / tissue requiring repair or removal?			
Calculated blood loss		**Referred for review**	**YES / NO**

OUTCOME: (continue over if necessary)

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