# Appendix D: Sample Forms

## OREGON DEPARTMENT OF HUMAN SERVICES

### HEALTH DIVISION

### CENTER FOR HEALTH STATISTICS

### CERTIFICATE OF DEATH

<table>
<thead>
<tr>
<th>1. DECEASED NAME</th>
<th>First</th>
<th>Last</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. SOCIAL SECURITY NUMBER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7a. SEX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7b. Date of Death (Month, Day, Year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8a. Date of Birth (Month, Day, Year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9b. Placenta (Specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Father - Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Mother - Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13a. Date of Issue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13b. Date of Expiry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Race (Specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15a. Education (Specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16a. Marital Status - Married, Divorced, or Single (Specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16b. Spouse (Name, Address)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16c. Place of Birth (City, Town, or Location)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16d. County of Birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Father - Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Mother - Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Place of Death (City, Town, or Location)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Date of Death (Month, Day, Year)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Original Vital Statistics Copy

45-2 Rev (3/00)
Appendix D: Sample Forms

Oregon Department of Human Services - Health Division

Adolescent Suicide Attempt Report

1. Name of hospital: ____________________________ County ____________________________

2. Date of attempt (Month/Day/Year): __________/________/________

3. Admitted as an in-patient? □ Yes  □ No  □ Transferred to another hospital (Specify) ____________________________

4. Patient or hospital chart number: ____________________________

5. Date of birth (Month/Day/Year): __________/________/________

6. Sex: □ Male  □ Female

7. Race: □ White  □ Black  □ Am. Indian  □ Hispanic  □ Other (Specify) ____________________________

8. Residence: City ____________________________ County ____________________________

9. Patient lives with:
   □ Both parents  □ Father only  □ Mother only  □ Foster parents  □ Friends  □ Parent and stepparent  □ Unknown  □ Other, homeless, etc. (Specify): ____________________________

10. Place of attempt:
    □ Own home  □ Another’s home  □ School  □ Other (Specify): ____________________________

11. Method or methods used in attempt:
    Poisoning by solid or liquid substance including drug or alcohol overdoses, and other potentially toxic substances
    Specify substance(s): ____________________________
    Hanging or suffocation - Specify method: ____________________________
    Firearms and explosives - Specify type (Hand gun, rifle, etc.) and body site: ____________________________
    Cutting or piercing - Specify instrument and body site: ____________________________
    Other means such as motor vehicle crash, drowning, fire, etc. - Specify: ____________________________

12. History of mental health issues:
    □ Acute depression  □ Chronic depression  □ Bipolar disorder  □ Adjustment disorder
    □ Conduct disorder  □ Other  □ Unknown  □ None

13. Number of previous suicide attempts made during lifetime:
    □ 1  □ 2  □ 3  □ 4  □ 5  □ 6  □ 7+  □ Attempts made, but # unknown  □ History unknown

14. Precipitating events and risk factors:
    □ Family discord  □ Argument or breakup with boyfriend/girlfriend  □ Peer pressure/argument
    □ School problems  □ Suicide or attempt by friend/relative  □ Pregnancy
    □ Death of friend/relative  □ Move or new school  □ None
    □ Physical abuse - Specify type and perpetrator, if known: ____________________________
    □ Sexual abuse or rape - Specify type and perpetrator, if known: ____________________________
    □ Alcohol and/or drug abuse - Specify substance(s): ____________________________
    □ Prior arrests and/or convictions of a crime - Specify: ____________________________
    □ Other - Specify: ____________________________

15. Did the youth tell others of his or her plan to attempt/commit suicide? □ Yes  □ No  □ Unknown
    if yes, whom did the youth tell? □ Parent  □ Friend  □ Teacher  □ Other

16. Was the youth referred for intervention? □ No  □ Yes - Specify to whom: ____________________________

17. Name of person completing report (Print): ____________________________ Dept: ____________________________

*Any hospital which treats as a patient a person under 18 years of age because the person has attempted to commit suicide;

*Shall cause that person to be provided with information and referral to in-patient or out-patient community resources, crisis intervention or other appropriate intervention by the patient's attending physician, hospital social work staff or other appropriate staff. * and

*Shall report statistical information to the Health Division of the Department of Human Services about the person... *
Oregon Department of Human Resources  
HEALTH DIVISION  

ADOLESCENT SUICIDE ATTEMPT REPORT:  
ZERO ATTEMPTS

1. Name of HOSPITAL______________________________ COUNTY______________________________

2. During the month of ______________, there have been ZERO teen suicide attempts treated here.

3. Contact person at this facility:_____________________________________________________________

   Title/Dept:________________________________ Phone:________________________

MAIL THIS FORM TO THE ADDRESS LISTED BELOW NO LATER THAN THE 15TH OF THE MONTH FOLLOWING ANY MONTH IN WHICH THERE WERE NO TEEN SUICIDE ATTEMPTS TREATED AT YOUR HOSPITAL:

Adolescent Suicide Report Program
Center for Health Statistics
PO Box 14050
Portland, OR 97293-0050

Telephone (503) 731-4354

OSHD Form 45-120 (Rev 12-97)