## Appendix D: Sample Forms

**OREGON DEPARTMENT OF HUMAN SERVICES**  
**HEALTH DIVISION**  
**CENTER FOR HEALTH STATISTICS**

**CERTIFICATE OF DEATH**

<table>
<thead>
<tr>
<th>Local File Number</th>
<th>State File Number</th>
<th>136-</th>
</tr>
</thead>
</table>

### DECEDEENT

1. **DECEDEENT'S NAME**
   - **First**
   - **Middle**
   - **Last**

2. **Social Security Number**
   - 5a. AGE Last Birthday (Years)
   - 5b. Under 1 Year
   - 5c. Under 1 Year
   - 6. BIRTHPLACE (City and State or Foreign Country)

3. **SEX**
   - 7. DATE OF DEATH (Month, Day, Year)
   - Yes No

4. **PLACE OF DEATH**
   - 8a. PLACE OF DEATH (Check only one)
   - Hospital
   - Inpatient
   - ER/Outpatient
   - DOA
   - Other
   - Nursing Home
   - Decedent's Home
   - Other (Specify)

5. **COUNTY OF DEATH**
   - 8b. CITY, TOWN, OR LOCATION OF DEATH

6. **FACILITY NAME**
   - 9a. IF not institution, give street and number
   - 9b. CITY, TOWN, OR LOCATION OF DEATH
   - 9c. COUNTY OF DEATH

7. **DECEDEENT'S CUSTOM OCCUPATION**
   - 10a. Occupation (give kind of work done during most of working life. Do not use retired)

8. **KIND OF BUSINESS/INDUSTRY**
   - 10b. KIND OF BUSINESS/INDUSTRY

9. **MARITAL STATUS**
   - 11a. MARRIED
   - 11b. NEVER MARRIED
   - 11c. WIDOWED
   - 11d. DIVORCED (Specify)

10. **SPOUSE**
    - 12a. IF Married, Widowed

11. **RACE**
    - 15a. AMERICAN INDIAN, BLACK, WHITE, ETC.
    - 15b. OTHER (Specify)

12. **DECEDEENT'S EDUCATION**
    - 16a. ELEMENTARY/SECONDARY (0-12)
    - 16b. COLLEGE (1-4 or 5+)

13. **INSIDE CITY LIMIT?**
    - 13a. INSIDE CITY LIMIT?

14. **ZIP CODE**
    - 13b. ZIP CODE

15. **DEATH DATE**
    - 14. WAS DECEASED OF HISPANIC ORIGIN?
    - 14a. SPECIFY NO OR YES
    - 14b. IF YES, SPECIFY CUBAN
    - 14c. MEXICAN
    - 14d. PUERTO RICAN
    - 14e. OTHER

16. **LOCATION**
    - 15. LOCATION (City and State or Foreign Country)

17. **FATHER'S NAME**
    - 17a. First
    - 17b. Middle
    - 17c. Last

18. **MOTHER'S NAME**
    - 18a. First
    - 18b. Middle
    - 18c. Last

19. **INFORMANT'S NAME**
    - 19a. NAME
    - 19b. ADDRESS
    - 19c. ZIP OF FACILITY

20. **METHOD OF DISPOSITION**
    - 20a. MAUSOLEUM
    - 20b. CREMATION
    - 20c. REMOVAL FROM STATE
    - DONATION

21. **SIGNATURE OF OREGON FUNERAL SERVICE LICENSEE OR PERSON ACTING AS such**
    - 21a. SIGNATURE
    - 21b. LICENSE NO.

22. **NAME, ADDRESS AND ZIP OF FACILITY**
    - 22a. NAME
    - 22b. ADDRESS
    - 22c. ZIP OF FACILITY

23. **DATE FILED**
    - 23a. MONTH
    - 23b. DAY
    - 23c. YEAR

24. **REGISTRAR'S SIGNATURE**

**TO BE COMPLETED BY CERTIFYING PHYSICIAN**

25. **DATE OF DEATH**
    - 25a. MONTH
    - 25b. DAY
    - 25c. YEAR

26. **TIME OF DEATH**
    - 26a. HOUR
    - 26b. MINUTE

27. **WAS MEDICAL EXAMINER NOTIFIED?**
    - 27a. YES
    - 27b. NO

28. **CONDITIONS OF DEATH**
    - 28a. INJURY OR ILLNESS WHICH GAVE RISE TO DEATH
    - 28b. INJURY OR ILLNESS WHICH GAVE RISE TO DEATH

29. **CAUSE OF DEATH**
    - 29a. INJURY OR ILLNESS WHICH GAVE RISE TO DEATH
    - 29b. INJURY OR ILLNESS WHICH GAVE RISE TO DEATH

30. **DATE SIGNED**
    - 30a. MONTH
    - 30b. DAY
    - 30c. YEAR

31. **TIME OF DEATH**
    - 31a. HOUR
    - 31b. MINUTE

32. **DATE PRONOUNCED DEAD**
    - 32a. MONTH
    - 32b. DAY
    - 32c. YEAR

33. **DATE SIGNED**
    - 33a. MONTH
    - 33b. DAY
    - 33c. YEAR

34. **NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER**
    - 34a. NAME
    - 34b. TITLE
    - 34c. ADDRESS
    - 34d. ZIP

35. **CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST DIED**

36. **IMMEDIATE CAUSE**
    - 36a. ENTER ONLY CAUSE PER LINE FOR (a), (b), AND (c.) Do not enter mode of dying, e.g. Cardiac or Respiratory Arrest.

37. **MANNER OF DEATH**
    - 40a. NATURAL
    - 40b. Accident
    - 40c. Suicide
    - 40d. Homicide
    - 40e. Legal Intervention

38. **AUTOPSY**
    - 38a. NO
    - 38b. Yes
    - 38c. Probably
    - 38d. Unknown

39. **DATE OF INJURY**
    - 41a. Month
    - 41b. Day
    - 41c. Year

40. **TIME OF INJURY**
    - 41d. HOUR
    - 41e. MINUTE

41. **INJURY AT WORK?**
    - 41f. Yes
    - 41g. No

42. **DATE OF INJURY AT WORK?**
    - 41h. MONTH
    - 41i. DAY
    - 41j. YEAR

43. **PLACE OF INJURY**
    - 41k. AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.
    - 41l. SPECIFY

44. **LOCATION**
    - 41m. STREET AND NUMBER OR RURAL ROUTE NUMBER, CITY OR TOWN, STATE

**RESERVED FOR REGISTRAR'S USE**

**ORIGINAL VITAL STATISTICS COPY**

**45-2 Rev (3/03)**
Appendix D: Sample Forms

Adolescent Suicide Attempt Report

1. Name of hospital: ______________________________ County ____________________________
   Date of attempt (Month/Day/Year): __________/________/________

2. Admitted as an in-patient? □ Yes □ No □ Transferred to another hospital (Specify) __________
   Patient or hospital chart number: __________________________

3. Date of birth (Month/Day/Year): __________/________/________
   Sex: □ Male □ Female
   Race: □ White □ Black □ Am. Indian □ Hispanic □ Other (Specify) __________________________
   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 exposures, and other potentially toxic substances
    Specify substance(s):
    Hanging or suffocation – Specify method:
    Firearms and explosives – Specify type (Handgun, rifle, etc.) and body site:
    Cutting or piercing – Specify instrument, etc.:
    Other means such as motor vehicle, etc., drowning, fire, etc. – Specify: __________________________

12. History of mental health issue:
    □ 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. __________________________

ORS 441.750 states that
*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.*

*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:______________________________________________________________________

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)