HCHS/SOL Death Certificate Form (DTH)

I. General Instructions

The Death Certificate Form is completed for all eligible fatal events. The abstractor should be familiar with the document titled "General Instructions for Completing Paper Forms" prior to completing this form. Event ID Number and Date and Staff ID Number and Completion Date should be completed in the form header section.
When the DTH is entered in the DMS, the system will provide a pop-up message indicating if an Informant Interview and Physician Questionnaire are required, based on responses to Items 4, 5 and 11.

II. Detailed Instructions

Q1. The first question asks if a death certificate was obtained. If the answer is "NO", then no further items can be abstracted and the DTH is complete for this event.

Q2. Date of Death: Record as listed on the death certificate.

Q3. Time of Death: Record as listed on the death certificate.

Q4. Answer "Yes" or "No" or "Unknown". Deaths occurring outside the regular acute care hospital are categorized as out of hospital deaths. This includes deaths in nursing homes and other chronic care facilities.
Q5. Death classification: Record as listed on the death certificate.
Out of hospital deaths also include persons dead on arrival at acute care hospitals, dying in outpatient or emergency departments or admitted without vital signs.
Responses 1,2 and 3 are considered out of hospital deaths.

Q6. Coroner's Case: Record "Yes" or "No" as indicated on the death certificate.
Q7-9. Name and Address of Coroner: Record the name and address of the coroner or medical examiner who signed the death certificate. Record all details as documented on the death certificate.

Q10. Autopsy: Record "Yes" if the death certificate indicates that an autopsy was performed.
If not recorded, select "No".

Q11. ICD-10 Code for Underlying cause of death: The underlying cause of death is the most important or primary cause that lead to the death. It may not be the same as the first or "immediate" cause, and is assigned by a nosologist or a computer, based on all available information.
Enter the ICD-10 Code for underlying cause. The first space should be a letter, followed by a two-digit number. There may also be a number to the right of the decimal point. If a digit to the right of the decimal is not given, leave the field blank. **Do not zero fill.**

Q12. All listed ICD-10 Codes: Record all other ICD-10 codes (up to ten), exactly as listed on the death certificate. Enter codes the same way as in Q11.

Q13. Causes of death: Transcribe the causes of death exactly as recorded on the death certificate. If two causes are listed on one line of the death certificate, record them similarly on the form.

Q.14. Other significant conditions: Transcribe the other significant conditions contributing to the death, exactly as recorded on the death certificate.

Q16. Interval between onset and death: Enter the category for the immediate cause of death, as recorded on the death certificate. If this is missing, select “7” for “unknown or not recorded”. “Instantaneous” should be recorded as “1” for “5 minutes or less”.

Q17. Was name and address of informant recorded: Record “Yes” or “No”

Q18. Informant: Most death certificates have a line for informant. Often this is the spouse, but it may be a co-worker, friend, etc. Record the name exactly as documented.

Q19. Record the address as documented on the death certificate.

Q20. Relationship of Informant: Record as listed on the death certificate. Select “3” if unknown.

Q21. If the informant is “other” than spouse, specify the relationship. If the relationship is “spouse” or “unknown” skip this question.

Q22. Was the name and address of the certifying physician recorded: Record “Yes” or “No”

Q23. Record the name of the certifying physician who signed the death certificate, if not the coroner or medical examiner.

Q.24. Record the address of the certifying physician as documented on the death certificate.