Description

While driving to work on October 5, 2010 at 0800am, Javier Luis Perez, lost control of his vehicle near 921 Automobile Blvd in Silver Spring, MD and crashed into several other vehicles. He sustained head and neck injuries and lacerations to his face. Witnesses on the scene called 9-1-1 and reported that Javier suddenly began driving erratically.

He was taken by ambulance to Memorial hospital where Dr. Samuel Spade performed emergency surgery. Unfortunately, the surgery was not successful and Dr. Spade pronounced him dead at October 5, 2010 at 11:25am. A nurse started an EHR and entered basic identifying information, including the patient's name, his birth date, sex, home address (including Country and County of residence) and social security number. Dr. Spade added his own details as the death pronouncer, including his name and provider NPI.

Mr. Perez's medical record indicated that he had a twenty year history of Epilepsy. Dr. Spade suspected that Javier had suffered a seizure while he was driving that morning, causing him to lose control of his vehicle. The doctor completed the cause of death section of the death certificate and included "Blunt head trauma" on line 1a and "Auto accident" on line 1b. He added "Epilepsy" to line 1c because he was of the opinion that this was the underlying cause of death. He indicated that the death was associated with a transportation event and that Javier was the driver. He also entered "Cerebrovascular Accident" as a significant condition related to the cause of death.

Dr. Spade entered the injury location and the death location and entered the date and time and location at which the injury occurred, as well as the date and time that he signed the death certificate. He also entered the manner of death was an accident and noted that Javier was a non-smoker and that the death did not result from an injury at work. He also noted that no autopsy results were available for this decedent. Finally, he noted his own identifying information as the death certifier and noted the death certifier type as a "Physician certified death certificate". All information related to filing the death certificate is transmitted via an ADT^A04 message from the EHR to the jurisdictional vital records office.

Comments

No Comments

Pre-condition

No PreCondition

Post-Condition

No PostCondition

Test Objectives

The message must provide: Patient demographic information in the PID segment to provide basic demographics to allow identification of the person and matching of the record with information from the funeral director as well as death reporting observations in the OBX Observation/Result segments and further information on the patient death and possible autopsy in the PDA segment. The test case provides an example of relevant elements of recording the death of a patient, and of collecting the information needed to support filing a death certificate.

Support for Date/Time of Birth

Support for Death Location
Support for Autopsy Indicator
Support for Coroner Indicator
Support for Observation Value
Support for Death Certificate Signed Date/Time
Support for Death Certified By
Support for Death Cause Other Significant Conditions
Support for Death Pronouncer Details
Support for Did death involve any injury of any kind

Support for Did Tobacco use contribute to death

Support for Disease onset to death interval
Support for Manner of Death
Support for Part\Line Number
Support for Street Address where death occurred if not facility

Evaluation Criteria
No evaluation criteria

Notes
No Note