MORTALITY REPORT

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The Law on Reporting Disease (R.A. 3573) and the Philippine AIDS Prevention and Control Act (R.A. 8504) requires physicians to report all diagnosed HIV infection to the HIV & AIDS Registrar at the Epidemiology Bureau, Department of Health. This form must be submitted at the time of the patient's death. Please write in CAPITAL LETTERS and CHECK the appropriate boxes.

1 **Date of Death:** ☐☐ Month ☐☐ Day ☐☐☐☐ Year **HIV Confirmatory Code:** _____

UNIQUE IDENTIFIER CODE

2

First 2 letters of mother's first name	First 2 letters of father's first name	Birth order	Month of Birth	Day of Birth	Year of Birth
☐☐	☐☐	☐☐	☐☐	☐☐	☐☐☐☐

DEMOGRAPHIC DATA

3 **Name (Full name)**

First Name | Middle Name | Last Name | Suffix (Jr., III, etc)

4 **Sex at birth**: ☐ Male ☐ Female **Age:** ☐☐ *(years)* **Age in months** (if less than 1 yr old): ☐☐ *(months)*

5 **Last place of residence:** City/Municipality _____ Province: _____

Permanent address: City/Municipality _____ Province: _____

Place of birth: City/Municipality _____ Province: _____

6 **Was living with a partner?** ☐ Yes ☐ No **With currently living children?** ☐ Yes ☐ No

7 **If female:** ☐ pregnant at the time of death ☐ pregnancy status unknown

CIRCUMSTANCES SURROUNDING DEATH

8 **Causes of Death** (*Please do not include modes of dying, such as cardiorespiratory failure; indicate instead the condition that caused the organ failure.)

Immediate cause Condition or disease that led directly to death*		ICD code:
due to / secondary to		
Antecedent cause/s Condition/s that led to the immediate cause of death		ICD code:
due to / secondary to		
Underlying cause Condition or disease that started the chain of events leading to death		ICD code:

9 **Other significant conditions contributing to death**

_____

10 **Opportunistic infections present prior to death (check all that apply):**

☐ Tuberculosis ☐ Cryptococcal meningitis ☐ Candidiasis ☐ None

☐ Pneumocystis pneumonia ☐ Cytomegalovirus infection ☐ Toxoplasmosis ☐ Other (please specify): _____

11 **Place of death:** City/Municipality: _____ Province: _____

PERSON/FACILITY PROVIDING INFORMATION

12 Name and Signature: _____ Date accomplished: _____

Contact Number: _____ Email Address: _____

Name of Facility *(if applicable)*: _____

Complete Mailing Address: _____

Please send this accomplished form to hivregistry.nec@gmail.com or to Epidemiology Bureau - Department of Health, Rm. 209 Building 19, San Lazaro Compound, Rizal Avenue, Sta. Cruz, 1003 Manila.
Contact Nos: (02) 310-1452 & (02) 651-7800 loc. 2952 | EB-DOH Form D (Mortality Report) v2017