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| MANDATORY REPORT OF A MATERNAL DEATH |
| Michigan Department of Health and Human Services |
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| Please send this report immediately after the death of a woman who was currently pregnant or was pregnant with 365 days of death. Report the event regardless of where the patient died. **Please provide as much detail as possible, and submit any associated medical records (e.g., discharge summaries, autopsy reports, EMS reports, etc.) along with this reporting form.**  |
|  |
| 1. | Name of woman |       |  |
|  |  | Last First Middle Maiden |  |
|  |
|  | Address |       |  |
|  |  | Street City State Zip |  |
|  |
| 2. | Date of death |       |  | 2. | Time of death |       |  |
|  |  |  |  |  |  |  |  |
|  |
| 3. | Date of birth |       |  |  |
|  |  |  |  |  |
|  |
| 4. | Woman’s Social Security Number |       |  |  |
|  |  |  |  |  |
|  |
| 5. | Pregnancy Status: |  |
|  | [ ]  | Pregnant at Death | Estimated Gestation |       |  |
|  |  |  |  |  |  |
|  |
|  | [ ]  | Live birth in past year | [ ]  | Miscarriage/Stillbirth in past year |
|  |  |  |  |  |  |
|  |
|  | Date of delivery |       |  |  |
|  |  |  |  |  |
|  |
|  | Name of birth hospital (if known) |       |  |
|  |  |  |  |
|  |
|  | Name of Obstetrician (if known) |       |  |
|  |  |  |  |
|  |
|  | Names of other hospitals woman was admitted to during the past year |       |  |
|  |  |  |  |
|  |       |  |
|  |  |  |
|  |
| 6. | Location of death |       |  |
|  |  |  |  |
|  |
| 7. | Hospital of death |       |  | City |       |  |
|  | If different from 5. above |  |  |  |  |  |  |
|  |
| 8. | Woman’s medical record number |       |  |
|  |  |  |  |
|  |
| 9. | Name of attending physician at death |       |  |
|  |  |  |  |
|  |
| 10. | Autopsy | [ ]  | None | [ ]  | Yes – at site of death | [ ]  | Yes – at other site |
|  |  |  |  |
| 11. | Cause of death |       |  |
|  |  |  |  |
|  |       |  |
|  |  |  |
| 12. | Name of medical examiner or hospital pathologist |       |  |
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| 13. | Name of facility or address where autopsy was performed |       |  |
|  |  |  |  |
|  |       |  |
|  |
| 14. | Report prepared by |       |  | Date |       |  |
|  |  |  |  |  |  |  |  |
|  |
| 15. | Name of organization |       |  | Telephone |       |  |
|  |  |  |  |  |  |  |  |
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| **PLEASE RETURN THIS FORM AND THE ASSOCIATED MEDICAL RECORDS TO:**Maternal Mortality SurveillanceBureau of Epidemiology and Population HealthMichigan Department of Health and Human ServicesSouth Grand Building333 South Grand Ave, 2nd FloorLansing, MI 48933 |