CASE NARRATIVE TEMPLATES

The following case narrative templates are built into the MMRIA data system.

The Case Narrative Template provides an overview of the pertinent details of the case and is a useful tool for introducing a case to the review team.

Additional narrative templates specific to the variety of sources in medical records (prenatal, Labor and Delivery, ED/Hospital Visits, Transport, and Autopsy) are designed to help guide you in collecting critical information and constructing a narrative story for ease of reading and review.

You may find it useful to develop the case narrative for the specific sources of information immediately after completing the data entry for that source. Once all records have been abstracted and the narrative templates completed, you can then copy and paste all of the separate narratives into the single Case Narrative form built into MMRIA.

Core Narrative Template:

She was a (AGE, PLACE OF BIRTH, RACE/ETHNICITY, MARRIAGE STATUS, LEVEL EDUCATION, OCCUPATION). She was a gravida ___ para ___, who died with cause of death ___, ___ DAYS /MONTHS, BEFORE, DURING OR AFTER DELIVERY. Medical history was significant for ___ (PRE-PREGNANCY RISK FACTORS OR PRE-EXISTING MEDICAL CONDITIONS). Pre-pregnancy BMI was ___. Life course issues significant for ________________ (PSYCHOSOCIAL FACTORS). Entry into prenatal care was at ___ weeks with ___ (#) visits at a ____ (DESCRIBE LOCATION) with a ____ (PROVIDER TYPE). Prenatal history was significant for ___ (INCLUDE IDENTIFIED OBSTETRIC RISK FACTORS). Referrals during prenatal period were to ________________ on ___ (DATE).

Health events prior to delivery included ________________. She presented to CLINIC/HOSPITAL/OTHER ____________ at ___ weeks gestation. Delivery was by a (PROVIDER TITLE) ____, method was ___, with ___ anesthesia. Obstetric complications included ____. Fetus/infant was ___ weeks gestation and weighed ___ pounds/ounces, Apgar scores were ___ and complications were ____. Postpartum period significant for developing ____. Mother and infant WERE/WERE NOT DISCHARGED (IF APPLICABLE) to ____. At ___ weeks postpartum, she presented to (DESCRIBE LOCATION) ________________. Postpartum period significant for ____________________.

(SUMMARIZE TERMINAL EVENT). On ___ (DATE) and ___ TIME, (INCLUDE CRITICAL SYMPTOMS, VITALS, LABS, TREATMENTS).

Autopsy was done by a ____ OR WAS NOT DONE. Significant findings included ______________. DESCRIBE IF ANY BEREAVEMENT SUPPORT OFFERED ______________.

Prenatal Care Record: Narrative Summary

She was a gravida ___ para ___ with a past obstetric history of ______________ (IDENTIFY ANY COMPLICATIONS OR HIGH RISK FACTORS) OR STATE NO SIGNIFICANT PAST OB HISTORY. Prior surgical history includes ______________. Her family medical history was positive for ______________. Pre-existing medical conditions included ______________. She was ___ (HEIGHT) and weighed _______. Her pre-pregnancy BMI was ___.

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REVIEW to ACTION
In the sentinel pregnancy, she entered care at ___ weeks gestation and weighed ___. She attended ___ (#) visits at a __________________ (DESCRIBE CLINIC SETTING), with a ___________ (PROVIDER TYPE) and had ___________ (TYPE OF INSURANCE). Screening was/was not performed for substance use and was ___________ (POSITIVE/NEGATIVE) for ___________. Screening was/was not performed for domestic violence and was found to be ___________ (POSITIVE/NEGATIVE; DESCRIBE IF POSITIVE). Additional social determinant factors identified include ___________.

The pregnancy was complicated by ___________ (DESCRIBE ANY COMPLICATIONS OR HIGH RISK FACTORS). She was referred to a(n) ___________ (DESCRIBE SPECIALIST) for ___________. Diagnostic procedures during pregnancy included ___________. Abnormal labs during pregnancy include ___________. Abnormal vital signs during pregnancy include ___________. During the sentinel pregnancy, she was on ___________ (IDENTIFY ALL MEDICATIONS).

ER/Hospital Visit Narrative Summary Template

Fill out a separate summary for each hospital visit and label each facility by a different number or letter. If admitted to the hospital, provide brief chronological synopsis of events that occurred during the hospital stay, including condition and vital signs when discharged.

She presented at ___ (WEEKS GESTATION) to the ______________ (ED OR L&D TRIAGE OR OTHER) in a ______________ (HOSPITAL LEVEL OF OB CARE OR TRAUMA/TRAUMA LEVEL) via ______________ (METHOD OF TRANSPORTATION) on ___ (DATE) at ___ (TIME). Her chief complaint was ___________. Her weight on admission was ___________ and her presenting vital signs were ___________. She was screened for ___________ (DESCRIBE TYPE OF SCREENING I.E. EMBOLISM, HEMORRHAGE, ECTOPIC, INFLUENZA, DOMESTIC VIOLENCE, ETC.).

Physical examination on admission found ___________. Labs performed included ___________ with the following abnormal findings noted ___________. Diagnostic tests performed included ___________ with the following abnormal findings noted ___________. Her diagnosis was ___________ and she was admitted to ______________ (DESCRIBE UNIT) OR was transferred to ______________ OR was discharged to ______________.

Labor and Delivery:

She labored for ___________ hours and delivered via ______________ (METHOD – IF CESAREAN SECTION, DESCRIBE REASON) by a(n) ___________ (PROVIDER TYPE) under ______________ (ANESTHESIA TYPE). Medications administered during labor and delivery or postpartum included ___________. She received ___________ units of blood products (DELETE IF NOT APPLICABLE). Infant weighed ___ with Apgar numbers of ___.
Complications during labor, delivery or postpartum included ________________.

She was discharged home on day ____. Vitals signs at discharge included ____. She was instructed to ________________ (SPECIAL EDUCATION OR FOLLOW-UP APPOINTMENTS).

Transport Narrative Summary:
Transport was notified on ___ (DATE) at ___ (TIME) for ________________ (REASON). Upon arrival at ________________ (PLACE OF ORIGIN) she was found to be ___ weeks gestation with ________________ (BRIEFLY DESCRIBE CONDITION). Procedures during transport included ________________. She was taken to ________________ (DESCRIBE DESTINATION, INCLUDING LEVEL OF CARE).

Autopsy Narrative Summary:
She expired on ___ (DATE) at ___ (TIME) in the ________________ (FACILITY). The case WAS OR WAS NOT reported to the Medical Examiner/Coroner. Autopsy WAS OR WAS NOT performed. Core findings from the autopsy include the following:
- Autopsy performed by
- Height and Weight
- Systems Exam (Gross Findings)
- Microscopic Exam
- Toxicology Results
- Cause of Death, per autopsy
REFERENCES
