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MMRIA is designed to capture your abstraction notes and help you to write a comprehensive Case Narrative that you can present to your committee. You may wish to abstract on paper and then enter the data into MMRIA, but it is ideal to enter case data into MMRIA before you present a case to your committee. Why?

1. The templates contained in the Reviewer’s Notes sections of each form and the Case Narrative form itself will aid you in writing a case narrative that can be easily printed for presentation to your committee.

2. Throughout the different forms in MMRIA, you will see fields denoted with an asterisk. Fields with asterisks denote core data elements. These fields are not required but are considered critical information for committee members to have when reviewing a case. All of the core elements are brought into a Core Elements Report that you may also wish to print for presentation to the committee. If you have this data available, make sure you complete the field. If it is not available, you may wish to note that in the Reviewer’s Notes text box at the bottom of each form.

3. If your committee members have MMRIA access, they can view de-identified case information prior to or during committee meetings.

Note: Be sure to exclude any personal identifiers from the Reviewer’s Notes sections of each form. Any identified information entered into Reviewer’s Notes sections of forms will NOT be de-identified for the Committee Reviewer role.
Home Record

First name: ____________________ Middle name: ____________________ Last name: ____________________

Date of Death*
Month: ________ Day: ________ Year: ________
  □ Estimate
State of death record*: ____________ (Note: This is auto-generated in MMRIA)
Record ID*: ____________
Agency-based case identifier:

How was this death identified? (Primary source)*:
  □ Obstetric ICD codes from death certificate
  □ Record linkage of death and birth/fetal death certificates
  □ Facility
  □ Pregnancy checkbox on death certificate
  □ Record linkage of death certificate and hospital discharge data
  □ Obituary
  □ Record linkage of death certificate and hospital discharge data
  □ Social Media
  □ Other
  □ Unknown

Specify other or additional sources: ____________________
Primary Abstractor: ____________________

Case Progress Report
Death certificate:
  □ Not started □ Completed □ Not applicable
  □ In progress □ Not available
Autopsy report:
  □ Not started □ Completed □ Not applicable
  □ In progress □ Not available
Birth/Fetal death certificate - Parent section:
  □ Not started □ Completed □ Not applicable
  □ In progress □ Not available
Birth/Fetal death certificate - Infant/Fetal section:
  □ Not started □ Completed □ Not applicable
  □ In progress □ Not available
Prenatal care record:
  □ Not started □ Completed □ Not applicable
  □ In progress □ Not available
ER visits and hospitalizations:
  □ Not started □ Completed □ Not applicable
  □ In progress □ Not available
Other medical office visits:
  □ Not started □ Completed □ Not applicable
  □ In progress □ Not available
Medical transport:
  □ Not started □ Completed □ Not applicable
  □ In progress □ Not available
Social and environmental profile:
  □ Not started □ Completed □ Not applicable
  □ In progress □ Not available
Mental health profile:
  □ Not started □ Completed □ Not applicable
  □ In progress □ Not available
Informant interviews:
  □ Not started □ Completed □ Not applicable
  □ In progress □ Not available
Case narrative:
  □ Not started □ Completed □ Not applicable
  □ In progress □ Not available
**Death Certificate**

**Maternal Death Certificate Identification**

Time of death: ____________  Local file no.: ______________  State file no.: ______________

**Place of Last Residence**

Street: ______________  State*: ______  Zip code: ______
City: ______________  Country*: ______________  County: ______________

**Demographics**

**Date of Birth**

Month: ____________  Day: ______  Year: ______

□ Estimate

Age at death*: ______

Marital status*:

□ Married  □ Divorced  □ Not specified

□ Married, but separated  □ Never married  □ Unknown

□ Widowed

City of birth: ______  State of birth: ______

Country of birth (if foreign born)*: ______________

Primary occupation*: ______________

Business/industry: ______________

Ever in U.S. armed forces?:

□ Yes  □ No  □ Not specified

□ Hispanic origin*:

□ Yes, Puerto Rican  □ Yes, Cuban  □ Not specified

□ Yes, Mexican, Mexican American, Chicano  □ Yes, other Spanish/Hispanic/Latino

□ No, not Spanish/Hispanic/Latino

Education*:

□ 8th grade or less  □ Some college; no degree  □ Doctorate or professional degree

□ 9th-12th grade; no diploma  □ Associate's degree  □ Not specified

□ High school grad or GED completed  □ Bachelor's degree  □ Master's degree

Citizen of what country?: ______________

**Race**

Race*:

□ White  □ Samoan  □ Chinese

□ Black  □ Other Pacific Islander  □ Japanese

□ American Indian/Alaska Native  □ Asian Indian  □ Vietnamese

□ Native Hawaiian  □ Filipino  □ Other race

□ Guamanian or Chamorro  □ Korean  □ Race not specified

□ Other race: ______________

□ Other Asian: ______________

□ Other Pacific Islander: ______________

Specify principal tribe: ______________
Death Certificate Cont.

Injury Associated Information

Date of Injury
Month: ___________ Day: ___________ Year: ___________
☐ Estimate
Time of injury: ___________
Place of injury (Place name, if applicable): ___________
Was injury at work?
☐ Yes ☐ No ☐ Not specified
Transportation-related injury?:
☐ Driver/Operator ☐ Pedestrian
☐ Passenger ☐ Other
Specify other: ___________
Were seatbelts in use?:
☐ Yes ☐ No ☐ Not available ☐ Not specified

Location Where Injury Occurred
Street: ___________ City: ___________ State: ___________ Zip code: ___________ County: ___________

Death Information
If death occurred in hospital*:
☐ Inpatient ☐ Home ☐ Not specified
☐ Outpatient/ER
☐ Hospice
☐ Nursing home/LTC
☐ Dead on arrival
☐ Other
Specify other: ___________
Manner of death*:
☐ Natural ☐ Suicide ☐ Could not be determined
☐ Homicide ☐ Self-inflicted ☐ Not specified
☐ Accident ☐ Pending investigation
Was autopsy performed?*
☐ Yes ☐ No ☐ Not specified
Was autopsy used for death coding?*
☐ Yes ☐ No ☐ Not specified
Pregnancy status*:
☐ Not pregnant within last year ☐ Pregnant 43 to 365 days of death
☐ Pregnant at the time of death ☐ Unknown if pregnant in last year
☐ Pregnant within 42 days of death
☐ Not specified
Did tobacco contribute to death?:
☐ Yes ☐ No ☐ Unknown ☐ Not specified

Location Where Death Occurred
Place of death (Facility name, if applicable): ___________
Street: ___________ State*: ___________ County: ___________
City: ___________ Zip code: ___________
## Death Certificate Cont.

### Causes of Death

<table>
<thead>
<tr>
<th>Type*</th>
<th>Cause (Descriptive)*</th>
<th>ICD Code</th>
<th>Interval</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

**Type (dropdown options in grid above)**
- [ ] Immediate
- [ ] Contributing
- [ ] Underlying
- [ ] Other significant

**Unit (dropdown options in grid above)**
- [ ] Minute(s)
- [ ] Hour(s)
- [ ] Day(s)
- [ ] Week(s)
- [ ] Month(s)
- [ ] Year(s)

### Reviewer's Notes about the Death Certificate


Facility of Delivery Demographics
Type of place*: □ Hospital □ Free-standing birthing center □ Home Delivery □ Clinic/Doctor's office □ Other
Was home delivery planned?: □ Yes □ No □ Not specified

Date of Delivery
Month: __________ Day: __________ Year*: __________
□ Estimate

Maternal level of care*: □ Birth center □ Subspecialty care (Level III) □ Regional perinatal health care center (Level IV) □ Basic care (Level I) □ Specialty care (Level II) □ Other

Specify other maternal level of care: __________________________
Facility NPI number: __________________ Facility Name: __________________
Attendant's Title*: □ MD □ DO □ CNM/CM □ Other □ Not specified

Specify Other Title: __________________________
Attendant's NPI: __________________

Was mother transferred?*: □ Yes □ No □ Not specified
If Yes, enter name of facility mother transferred from: __________________________

Facility of Delivery Location
Street: __________________ State*: ________ County: ________________
City: ________________ Zip code: ________________

Father's Demographics
Father's first name: ________ Father's middle name: ________ Father's last name: ________
Date of Birth: ________
Month: __________ Day: ________ Year: ________
□ Estimate
Age: ________
Father's education:
□ 8th grade or less □ Some college; no degree □ Doctorate or professional degree
□ 9th-12th grade; no diploma □ Associate's degree □ Bachelor's degree □ Not specified
□ High school grad or GED completed □ Master's degree

Father's city of birth: ________________ Father's state of birth: ________
Father's country of birth (if foreign born): ________________
Father's primary occupation: ________________
Business/industry: ________________
Father of Hispanic origin?: □ No, not Spanish/Hispanic/Latino □ Yes, Puerto Rican □ Yes, origin unknown
□ Yes, Mexican, Mexican American, Chicano □ Yes, Cuban □ Not specified
□ Yes, Other Spanish/Hispanic/Latino
Father's Race
Father's race (select all that apply):

- □ White
- □ Black
- □ American Indian/Alaska Native
- □ Native Hawaiian
- □ Guamanian or Chamorro
- □ Samoan
- □ Other Pacific Islander
- □ Asian Indian
- □ Filipino
- □ Korean
- □ Other Asian
- □ Chinese
- □ Japanese
- □ Vietnamese
- □ Other race
- □ Race not specified

Specify other race: _____________
Specify other Asian: _____________
Specify other Pacific Islander: _____________
Specify principal tribe: _____________

Maternal Record Identification
First name: _____________
Middle name: _____________
Last name: _____________
Maiden name: _____________
Medical record number: _____________

Mother's Demographics
Date of birth
Month: ______
Day: ______
Year: ______
□ Estimate
Age*: ______
Mother Married?*:
□ Yes
□ No
□ Not specified

If mother not married, has paternity acknowledgement been signed in the hospital?:
□ Yes
□ No
□ Not specified

Mother's city of birth: _____________
Mother's state of birth (U.S.): _____________
Mother's country of birth (if foreign born)*: _____________
Primary Occupation: _____________
Business/industry: _____________

Ever in U.S. armed forces?:
□ Yes
□ No
□ Not specified

Mother of Hispanic origin?*:
□ No, not Spanish/Hispanic/Latino
□ Yes, Mexican, Mexican American, Chicano
□ Yes, Puerto Rican
□ Yes, Cuban
□ Yes, other Spanish/Hispanic/Latino
□ Yes, origin unknown
□ Not specified

Education*:
□ 8th grade or less
□ 9th-12th grade; no diploma
□ High school grad or GED completed
□ Some college; no degree
□ Associate's degree
□ Bachelor's degree
□ Master's degree
□ Doctorate or professional degree
□ Not specified
Location of Residence
Street: ________________  State*: ________  County: __________________________
City: ________________  Zip code: ________________

Mother’s Race
Mother’s race (select all that apply)*:
□ White  □ Samoan  □ Chinese
□ Black  □ Other Pacific Islander  □ Japanese
□ American Indian/Alaska  □ Asian Indian  □ Vietnamese
□ Native  □ Filipino  □ Other race
□ Native Hawaiian  □ Korean  ○ Race not specified
□ Guamanian or Chamorro  □ Other Asian

Specify other race: ______
Specify other Asian: ______
Specify other Pacific Islander: ______
Specify principal tribe: ______

Pregnancy History

Date of Last Live Birth
Month: ________  Day: ________  Year: ________
□ Estimate
Number of previous live births (Do not include this child)*: __________
Now living: __________
Now dead: __________
Number of other pregnancy outcomes*: ______

Date of Last Other Pregnancy Outcome
Month: ________  Day: ________  Year: ________
□ Estimate

Maternal Biometrics
Height (Feet): __________  Weight at delivery (lbs.): __________
Height (Inches): __________  Weight Gain during pregnancy (lbs.): __________
Pre-pregnancy weight (lbs.): __________  Pre-pregnancy BMI*: __________

Prenatal Care
Date Last Normal Menses Began
Month: ________  Day: ________  Year: ________
□ Estimate

Date of First Prenatal Care Visit
Month: ________  Day: ________  Year: ________
□ Estimate

Date of Last Prenatal Care Visit
Month: ________  Day: ________  Year: ________
□ Estimate
Obstetric estimate of gestation at birth (completed weeks)*: __________
Plurality*:
□ Singleton  □ Triplets  □ Not specified
□ Twins  □ More than 3
Specify, if > 3: ______
Did mother get WIC food for herself during this pregnancy?: □ Yes □ No □ Not specified
Principal source of payment for this delivery*: □ Private insurance □ Self □ Medicaid □ Other
Specify other payor: __________
Trimester of first prenatal care visit*: □ First □ Third
□ Second □ No prenatal care
Total number of prenatal visits for this pregnancy: __________

Cigarette Smoking Before and During Pregnancy
Three months before pregnancy (# of cigarettes/packs): ________ Unit(s):
□ Cigarette(s) □ Pack(s)
First three months of pregnancy (# of cigarettes/packs): ________ Unit(s):
□ Cigarette(s) □ Pack(s)
Second three months of pregnancy (# of cigarettes/packs): ________ Unit(s):
□ Cigarette(s) □ Pack(s)
Third trimester of pregnancy (# of cigarettes/packs): ________ Unit(s):
□ Cigarette(s) □ Pack(s)
None or not specified: □ None □ Not specified

Maternal Risk Factors
Risk factors in this pregnancy*: □ Prepregnancy diabetes □ Gestational diabetes
□ Prepregnancy hypertension □ Gestational hypertension
□ Eclampsia hypertension □ Previous preterm birth
□ Mother had a previous cesarean delivery
Number of C-sections: ________
□ None of these □ Not specified
Infections present or treated during this pregnancy*: □ Hepatitis B (live birth only) □ Hepatitis C (live birth only)
□ Gonorrhea □ Syphilis □ None of these
□ Listeria □ Cytomegalovirus □ Chlamydia □ Parvovirus
□ Not specified
□ Pregnancy resulted from infertility treatment
□ Fertility enhancing drugs, artificial insemination or intrauterine insemination
□ Assisted reproductive technology (e.g. in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))
□ Group B Streptococcus (fetal death(s) only)
□ Toxoplasmosis (fetal death(s) only)
□ Precipitous labor (< 3 hours)
□ Prolonged labor (> 20 hours)
Onset of labor (choose all that apply)*: □ Premature rupture of membranes (prolonged)
□ None of these □ Not specified
Obstetric procedures (select all that apply)*: □ Cervical cerclage □ External cephalic version: Successful
□ Tocolysis □ External cephalic version: failed □ None of these □ Not specified
# Characteristics of labor and delivery (select all that apply)*:
- [ ] Induction of labor
- [ ] Steroids (glucocorticoids) for fetal lung maturation received by mother prior to delivery
- [ ] Clinical chorioamnionitis diagnosed during labor or maternal temperature \( \geq 38 \) degrees C (100.4 degrees F)
- [ ] Epidural or spinal anesthesia during labor
- [ ] Augmentation of labor
- [ ] None of these

# Maternal morbidity (select all that apply)*:
- [ ] Maternal transfusion
- [ ] Unplanned hysterectomy
- [ ] Unplanned operating room procedure following delivery
- [ ] None of these
- [ ] Antibiotics received by the mother during labor
- [ ] Moderate to heavy meconium staining of the amniotic fluid
- [ ] Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
- [ ] Non-vertex presentation
- [ ] Not specified
- [ ] Third or fourth degree perineal laceration
- [ ] Admission to intensive care unit
- [ ] Ruptured uterus
- [ ] Not specified

---

**Reviewer’s Notes about the Parent Section of the Birth or Fetal Death Certificate**

---
Birth/Fetal Death Certificate - Infant/Fetal Section

Record: ______________________
Record type*: 
□ Live Birth  □ Fetal Death
□ Multiple Gestation
Birth order: ______________________

Newborn (Fetus) Record Identification
First name: ______________________ Middle name: ______________________ Last name: ______________________
State file no.: ______________________
Local file no.: ______________________
Newborn medical record no.: ______________________
Time of delivery: ______________________

Newborn (Fetus) Biometrics and Demographics

Birth Weight
Unit of measurement: 
□ Grams  □ Pounds/Ounces
Value (grams or pounds)*: ______________________
Value (ounces)*: ______________________
Gender: 
□ Male  □ Unknown
□ Female  □ Not specified

Apgar Scores
5 minute: ______________________ 10 minute: ______________________
Is infant living at time of report?: 
□ Yes □ No  □ Infant transferred, status unknown  □ Not specified
Is infant being breastfed at discharge?: 
□ Yes □ No  □ Not specified
Was infant transferred within 24 hours of delivery?: 
□ Yes □ No  □ Not specified
Specify facility, city and state: ______________________

Method of Delivery
A. Was delivery with forceps attempted but unsuccessful?: 
□ Yes □ No  □ Not specified
B. Was delivery with vacuum extraction attempted but unsuccessful?: 
□ Yes □ No  □ Not specified
C. Fetal presentation at birth:
□ Cephalic □ Compound  □ Not specified
□ Breech □ Other
□ Shoulder □ Unknown
Other Presentation: ______________________
D. Final route and method of delivery*: 
□ Vaginal/spontaneous □ Vaginal/vacuum  □ Other
□ Vaginal/forceps □ Cesarean  □ Not specified
If Cesarean, was a trial of labor attempted?: 
□ Yes □ No  □ Not specified
Abnormal conditions of the newborn (select all that apply):
- Assisted ventilation required immediately following delivery
- Newborn given surfactant replacement therapy
- Seizure or serious neurologic dysfunction
- Assisted ventilation required for more than 6 hours
- NICU admission
- Antibiotics received by the newborn for suspected neonatal sepsis
- Significant birth injury (skeletal fracture(s), peripheral nerve injury and or soft tissue or solid organ hemorrhage which requires intervention)
- Abnormal conditions not specified
- None of the above

Congenital anomalies of the newborn or fetus (select all that apply):
- Anencephaly
- Cyanotic congenital heart disease
- Omphalocele
- Limb reduction defect (excluding congenital amputation and dwarving syndromes)
- Cleft Lip with or without Cleft Palate
- Downs Syndrome
- Karyotype confirmed - Downs Syndrome
- Karyotype pending - Downs Syndrome
- Hypospadias
- Meningomyelocele or Spina bifida
- Congenital diaphragmatic hernia
- Gastrochisis
- Cleft palate alone
- Suspected chromosomal disorder
- Karyotype confirmed - Suspected chromosomal disorder
- Karyotype pending - Suspected chromosomal disorder
- Congenital anomalies not specified
- None of the above

Causes of Fetal Death

<table>
<thead>
<tr>
<th>Type</th>
<th>Class</th>
<th>Complication Subclass</th>
<th>Other (Specify)</th>
<th>ICD Code</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Reviewer’s Notes about the Birth Certificate- Infant/Fetal Section
**Autopsy Report**

**Autopsy Report**
Was an autopsy performed?:
- □ Referred/performed/available
- □ Referred/performed/not available
- □ Referred/not performed
- □ Not referred

Completeness of autopsy information*:
- □ Complete
- □ Minor gaps
- □ Major gaps
- □ Minimal

**Reporter Characteristics**

Reporter type:
- □ Medical examiner
- □ Coroner
- □ Other
- □ Unknown
- □ Not Specified

Other (specify): __________

**Date of Autopsy**

Month: __________
Day: __________
Year: __________

- □ Estimate

Jurisdiction: __________

**Biometrics**

**Mother Height**
Feet: __________
Inches: __________

Weight (lbs): __________
BMI*: __________

**Fetus (if applicable)**

Fetal weight (grams): __________
Fetal Length (inches): __________

Estimate of gestational age (Weeks): __________

**Findings Relevant to Maternal Death**

**Gross findings**

<table>
<thead>
<tr>
<th>Finding</th>
<th>Comment(s)</th>
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</tbody>
</table>

**Microscopic findings**

<table>
<thead>
<tr>
<th>Finding</th>
<th>Comment(s)</th>
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<tbody>
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</tbody>
</table>

**Was toxicology positive for drugs?***:
- □ Yes
- □ Not done
- □ No
- □ Done, but not available
### Toxicology*

<table>
<thead>
<tr>
<th>Substance (dropdown options in grid above)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Acetaminophen</td>
<td>□ Heroin</td>
</tr>
<tr>
<td>□ Acetazolamide (Diamox)</td>
<td>□ Hydromorphone (Dilaudid)</td>
</tr>
<tr>
<td>□ Alcohol</td>
<td>□ Lorazepam (Ativan)</td>
</tr>
<tr>
<td>□ Alprazolam (Xanax)</td>
<td>□ Lurasidone (Latuda))</td>
</tr>
<tr>
<td>□ Aripiprazole (Abilify)</td>
<td>□ Meprobamate (Equanil)</td>
</tr>
<tr>
<td>□ Aminoclonazepam</td>
<td>□ Methadone</td>
</tr>
<tr>
<td>□ Buprenorphine</td>
<td>□ Methadone Hydrochloride</td>
</tr>
<tr>
<td>□ Carbamazepine (Neurontin)</td>
<td>□ Midazolam (Versed)</td>
</tr>
<tr>
<td>□ Chlordiazepoxide (Librium)</td>
<td>□ Morphine Sulfate</td>
</tr>
<tr>
<td>□ Citalopram (Celexa)</td>
<td>□ Oxycodone Hydrochloride</td>
</tr>
<tr>
<td>□ Clonazepam (Klonopin or Rivotril)</td>
<td>□ Oxymorphone Hydrochloride (Opana)</td>
</tr>
<tr>
<td>□ Cocaine</td>
<td>□ Pregabalin (Lyrica)</td>
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<tr>
<td>□ Diazepam (Valium)</td>
<td>□ Quetiapine (Seroquel)</td>
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<tr>
<td>□ Doxepin (Silenor, Zonalon, Prudoxin)</td>
<td>□ Sertraline (Zoloft)</td>
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<td>□ Duloxetine (Cymbalta)</td>
<td>□ Temazepam (Restoril)</td>
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<tr>
<td>□ Felbamate (Felbatol)</td>
<td>□ Trazadone (Oleptro))</td>
</tr>
<tr>
<td>□ Fentanyl</td>
<td>□ Zolpidem (Ambien)</td>
</tr>
<tr>
<td>□ Fluoxetine/Olanzapine (Symbyax)</td>
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</table>

ICD Code Version: ____________

### Coroner/Medical Examiner Causes of Death

<table>
<thead>
<tr>
<th>Type (dropdown options in grid above)</th>
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<tbody>
<tr>
<td>□ Immediate</td>
<td>□ Underlying</td>
</tr>
<tr>
<td>□ Contributing</td>
<td>□ Other significant</td>
</tr>
</tbody>
</table>
Reviewer's Notes about the Autopsy Report

Note: For this section, briefly describe in chronological fashion the events immediately preceding the terminal event.

For example:

On _________ (date) at _____ (time)...
(Include critical symptoms, treatments, referrals, labs, and vitals)
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):

List any other relevant notes:
Prenatal Care Record

Prenatal Care Record No.: ________________

Was there more than one prenatal care source?
☐ Single  ☐ Multiple

Primary Prenatal Care Facility
Place type:
☐ Hospital  ☐ Other  ☐ Not specified
☐ Clinic  ☐ Unknown
☐ Office  ☐ No prenatal care
Specify other place type: ____________________

Primary provider type:
☐ OBGYN  ☐ Family practice  ☐ Other
☐ MFM  ☐ Other subspecialist  ☐ Unknown
Specify other provider type: ____________________

Principal source of payment*:
☐ Private insurance  ☐ Self-pay  ☐ Unknown
☐ Medicaid  ☐ Other  ☐ Not specified
Specify other payment source: ____________________

Use of WIC*:
☐ Yes  ☐ No  ☐ Not specified

Location of Primary Prenatal Care Facility
Street: ________________  State*: ________________  County: ________________
City: ________________  Zip code: ________________

Prior Surgical Procedures before this Pregnancy

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
<th>Comment(s)</th>
</tr>
</thead>
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Were there documented preexisting medical conditions?*:
☐ Yes  ☐ No  ☐ Not specified

Pre-existing Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Other (specify)</th>
<th>Duration</th>
<th>Comment(s)</th>
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</table>

Condition(s) (dropdown options in grid above)
☐ Hypertension  ☐ Asthma  ☐ Type I Diabetes
☐ Heart Disease  ☐ Systemic Lupus  ☐ Type II Diabetes
☐ Sickle Cell Disease  ☐ Erythematous  ☐ Malignancy
☐ Anemia (pre-pregnancy)  ☐ Seizure Disorder  ☐ Other

Were there documented mental health conditions?*:
☐ Yes  ☐ No  ☐ Not specified
### Prenatal Care Record cont.

#### Family Medical History

<table>
<thead>
<tr>
<th>Relation</th>
<th>Condition</th>
<th>Living?</th>
<th>Age at Death</th>
<th>Comment(s)</th>
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</thead>
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</table>

Relation (dropdown options in grid above)
- □ Mother
- □ Father
- □ Sister
- □ Brother
- □ Grandparent
- □ Cousin
- □ Aunt/Uncle

Living (dropdown options in grid above)
- □ Yes
- □ No
- □ Not specified

Was there evidence of substance use?:
- □ Yes
- □ No
- □ Not specified

#### Evidence of Substance Use

<table>
<thead>
<tr>
<th>Substance</th>
<th>Screening</th>
<th>Counseling/Education</th>
<th>Comment(s)</th>
</tr>
</thead>
<tbody>
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</table>

Screening (dropdown options in grid above)
- □ Yes
- □ No
- □ Not specified

Substances (dropdown options in grid above)
- □ Acetaminophen
- □ Acetazolamide (Diamox)
- □ Alcohol
- □ Alprazolam (Xanax)
- □ Aripiprazole (Abilify)
- □ Aminoclonazepam
- □ Buprenorphine
- □ Carbamazepine (Neurontin)
- □ Chlor diazepoxide (Librium)
- □ Citalopram (Celexa)
- □ Clonazepam (Klonopin or Rivotril)
- □ Cocaine
- □ Diazepam (Valium)
- □ Doxepin (Silenor, Zonalon, Prudoxin)
- □ Duloxetine (Cymbalta)
- □ Felbamate (Felbatol)
- □ Fentanyl
- □ Fluoxetine/Olanzapine (Symbyax)
- □ Heroin
- □ Hydromorphone (Dilaudid)
- □ Lorazepam (Ativan)
- □ Lurasidone (Latuda)
- □ Meprobamate (Equanil)
- □ Methadone
- □ Methadone Hydrochloride
- □ Midazolam (Versed)
- □ Morphine Sulfate
- □ Oxycodone Hydrochloride
- □ Oxymorphone Hydrochloride (Opana)
- □ Pregabalin (Lyrica)
- □ Quetiapine (Seroquel)
- □ Sertraline (Zoloft)
- □ Temazepam (Restoril)
- □ Trazadone (Oleptro)
- □ Zolpidem (Ambien)
**Prenatal Care Record cont.**

**Pregnancy History**
Gravida*: ____________  Para*: ________________  Abortions*: ________________

### Specify Details Below

<table>
<thead>
<tr>
<th>Date</th>
<th>Outcome</th>
<th>GA (weeks)</th>
<th>Birth weight (g)</th>
<th>Method of delivery</th>
<th>Complications</th>
<th>Now living?</th>
</tr>
</thead>
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</table>

- **Now living (dropdown options in grid above)**
  - Yes
  - No
  - Not specified

- **Outcome (dropdown options in grid above)**
  - Live birth
  - Miscarriage
  - Ectopic
  - Miscarriage
  - Abortion
  - Other

### Intendedness (Current Pregnancy)

**Was pregnancy planned?**
- Planned
- Unwanted
- Unknown
- Mistimed
- Other
- Not specified

**Was patient using birth control?**
- None
- Barrier
- Unknown
- Hormone
- Rhythm
- Not specified
- IUD
- Other

**Date Birth Control was Discontinued**
Month: ____________  Day: ________________  Year: ________________
- Estimate

### Infertility Treatment (Current Pregnancy)

**Did this pregnancy result from infertility treatment?**
- Yes
- No
- Not specified

- **Fertility enhancing drugs:**
  - Yes
  - No
  - Not specified

- **Assisted Reproductive Technology (ART):**
  - Yes
  - No
  - Not specified

- **ART type:**
  - In vitro fertilization (IVF)
  - Gamete intrafallopian transfer (GIFT)
  - Other
  - Zygote intrafallopian transfer (ZIFT)
  - Intracytoplasmic sperm injection (ICSI)
  - Unknown

- **Specify other ART type:** ________________

- **Cycle number:** ____________

- **Embyos transferred:** ________________

- **Embyos growing:** ________________

### Current Pregnancy

**Date of Last Normal Menses**
Month: ____________  Day: ________________  Year: ________________
- Estimate
Prenatal Care Record cont.

Estimated Date of Confinement (Estimated Date of Delivery)
Month: ________  Day: ________  Year: ________
☐ Abstractor estimate
☐ Estimate based on ultrasound
☐ Estimate based on LMP

Date of First Prenatal Visit*
Month: ________  Day: ________  Year: ________
☐ Estimate
Gestational age at first prenatal visit - weeks: ________
Gestational age at first prenatal visit - days: ________

Date of First Ultrasound
Month: ________  Day: ________  Year: ________
☐ Estimate
Gestational age from first ultrasound - weeks: ________
Gestational age from first ultrasound - days: ________

Date of Last Prenatal Visit
Month: ________  Day: ________  Year: ________
☐ Estimate
Gestational age at last prenatal visit - weeks: ________
Gestational age at last prenatal visit - days: ________

Maternal Biometrics
Height*
Feet: ________  Inches: ________

Weight:
Pre-pregnancy weight (lbs)*: ________  Weight at first visit (lbs)*: ________
BMI*: ________  Weight at last visit (lbs)*: ________
Weight gain (lbs)*: ________

Total number of prenatal care visits*: ________
Trimester of first prenatal care visit*:
☐ First  ☐ Second  ☐ Third  ☐ None
Number of Fetuses: ________
Was home delivery planned?:
☐ Yes  ☐ No  ☐ Not specified
Attended prenatal care visits alone?*
☐ Yes  ☐ No  ☐ Not specified

Name, city and state of intended birthing facility: ____________
### Routine Monitoring

<table>
<thead>
<tr>
<th>Date</th>
<th>GA - weeks</th>
<th>GA - Days</th>
<th>Systolic BP</th>
<th>Diastolic BP</th>
<th>Urine Protein</th>
<th>Urine Ketones</th>
<th>Urine Glucose</th>
<th>HCT (%)</th>
<th>Weight (lbs)</th>
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</table>

Urine Protein, Ketones and Glucose values (dropdown options in grid above)

- □ Negative
- □ Trace
- □ 1+
- □ 2+
- □ 3+
- □ 4+

### Highest Blood Pressure*

Systolic: __________
Diastolic: __________

Lowest Hematocrit*: __________

### Other Laboratory Tests

<table>
<thead>
<tr>
<th>Date</th>
<th>GA - weeks</th>
<th>GA - days</th>
<th>Test/Procedure</th>
<th>Results (units)</th>
<th>Comment(s)</th>
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### Diagnostic Procedures

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<thead>
<tr>
<th>Date</th>
<th>GA - weeks</th>
<th>GA - days</th>
<th>Procedure</th>
<th>Comments</th>
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</table>

Were there problems identified during the current pregnancy?*:

- □ Yes
- □ No
- □ Not specified

### Specify Details Below

<table>
<thead>
<tr>
<th>Date 1st noted</th>
<th>GA - weeks</th>
<th>GA - days</th>
<th>Problem</th>
<th>Comment(s)</th>
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Were There Any Adverse Reactions?*:

- □ Yes
- □ No
- □ Not specified
## List of Medications/Drugs during Pregnancy

<table>
<thead>
<tr>
<th>Date</th>
<th>GA - weeks</th>
<th>GA - days</th>
<th>Medication</th>
<th>Dose/ Frequency/ Duration</th>
<th>Reason</th>
<th>Adverse reaction</th>
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</table>

Adverse reactions (dropdown options in grid above)
- □ Yes
- □ No
- □ Not Specified

Were there pre-delivery hospitalizations or ER visits?:
- □ Yes
- □ No
- □ Not specified

## Pre-Delivery Hospitalizations Details

<table>
<thead>
<tr>
<th>Date</th>
<th>GA - weeks</th>
<th>GA - days</th>
<th>Facility</th>
<th>Duration</th>
<th>Reason</th>
<th>Comment(s)</th>
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## Medical Referral Details

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<tr>
<th>Date</th>
<th>GA - weeks</th>
<th>GA - days</th>
<th>Type of Specialist</th>
<th>Reason</th>
<th>Appointment kept</th>
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Appointment kept (dropdown options in grid above)
- □ Yes
- □ No
- □ Not specified

## Sources of Prenatal Care Information, Other than the Primary Provider (Transferred Records)

<table>
<thead>
<tr>
<th>Place</th>
<th>Provider type</th>
<th>City</th>
<th>State</th>
<th>Begin Date</th>
<th>End Date</th>
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</table>

Place (dropdown options in grid above)
- □ Hospital
- □ Clinic
- □ Office
- □ Other
- □ Unknown
- □ No prenatal care
- □ Not specified

Provider type (dropdown options in grid above)
- □ OBGYN
- □ MFM
- □ Family practice
- □ Other
- □ Other subspecialist
- □ Unknown
Reviewer’s Notes About the Prenatal Care Records
Note: For this section, a sample entry could include:

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_____. 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 +/-for _____________________. Screening was/was not performed for domestic violence and was found to be +/- (describe if +) _______________. 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).

List any other relevant notes.
ER Visits and Hospitalizations

Record: __________
Medical Record Number: __________

Basic Admission and Discharge Information

Date of Arrival at Hospital/ER
Month: ________  Day: ________  Year: ________
☐ Estimate

Gestational age - weeks: ______  Gestational age - days: ______  Days postpartum: ______

Time of Arrival: ________

Date of Admission to Hospital
Month: ________  Day: ________  Year: ________
☐ Estimate

Time of admission: __________

Gestational age - weeks: ______  Gestational age - days: ______  Days postpartum: __________

Admission condition:
☐ Stable  ☐ Critical  ☐ Not specified
☐ Serious  ☐ Unknown

Admission status:
☐ Admitted directly to the hospital
☐ Admitted through the ER
☐ ER visit only
☐ Other

Specify other status: __________

Admission reason:
☐ In labor
☐ Planned induction/C-section
☐ Complications of pregnancy, not in labor
☐ Postpartum complications
☐ Medical reasons not related to pregnancy
☐ Other

Specify other reason: __________

Was mother received from another hospital?:
☐ Yes  ☐ No  ☐ Not specified

From where? __________

Was mother transferred to another hospital?:
☐ Yes  ☐ No  ☐ Not specified

To where? __________

Date of Discharge from ER/Hospital
Month: ________  Day: ________  Year: ________
☐ Estimate

Time of discharge: ________

Gestational age - weeks: ______  Gestational age - days: ______  Days postpartum: ______

Discharge pregnancy status*:
☐ Pregnant, released undelivered
☐ Not pregnant, but pregnant within the last 12 months
☐ Not evaluated for pregnancy
☐ Not specified
☐ Pregnant, released postpartum
☐ Not pregnant, prior 12 months unknown

☐ Deceased at time of discharge?*
**Name and Location of Facility**

Facility name: ______

Type of Facility*:  
- [ ] Hospital  
- [ ] Free-standing birth center  
- [ ] Clinic/doctor’s office

Facility NPI number: ______

Maternal level of care*:  
- [ ] Birth center  
- [ ] Basic care (Level I)  
- [ ] Specialty care (Level II)  
- [ ] Subspecialty care (Level III)  
- [ ] Regional perinatal health care center (Level IV)  
- [ ] Other

Specify other maternal level of care: ______________________

Street: ___________  
City: ___________  
State: ___________  
Zip Code: ___________  
County: ___________

Mode of Transportation to Facility:  
- [ ] Private vehicle  
- [ ] Ambulance  
- [ ] Taxi  
- [ ] Bus  
- [ ] Other  
- [ ] Unknown

Specify other mode of transportation: ______________________

Origin of travel:  
- [ ] Home  
- [ ] Work  
- [ ] Other  
- [ ] Unknown

Specify other origin: ______________________

**Travel Time to Hospital**

Value: ______

Unit:  
- [ ] Minute(s)  
- [ ] Hour(s)  
- [ ] Day(s)

**Internal Transfers**

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>From Unit</th>
<th>To Unit</th>
<th>Comment(s)</th>
</tr>
</thead>
<tbody>
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</table>

**Maternal Biometrics**

Admission weight (lbs): ______  
Height feet: ______  
BMI: ______

**Physical Examinations and Evaluations**

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Exam/Evaluation</th>
<th>Findings</th>
<th>Performed By?</th>
</tr>
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<tbody>
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</table>

**Psychological Examinations and Assessments**

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Exam/Assessment</th>
<th>Findings</th>
<th>Performed By?</th>
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</table>
### Laboratory Tests

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Specimen</th>
<th>Test Name</th>
<th>Result</th>
<th>Diagnostic Level</th>
<th>Flag</th>
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Flag (dropdown options in grid above)
- □ Highest
- □ Lowest

Diagnostic level (dropdown options in grid above)
- □ Within normal limits
- □ Markedly decreased
- □ Markedly increased
- □ Mildly decreased
- □ Mildly increased
- □ Not applicable
- □ Decreased
- □ Increased
- □ Not specified

### Pathology

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Specimen</th>
<th>Exam Type</th>
<th>Findings</th>
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<tbody>
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### Onset of Labor

**Date of Onset of Labor**
- Month: ______
- Day: ______
- Year: ______
- □ Estimate
- Time: ______

**Date of Rupture of Membranes**
- Month: ______
- Day: ______
- Year: ______
- □ Estimate
- Time: ______

**Final Delivery Route***:
- □ Vaginal/spontaneous
- □ Vaginal/vacuum
- □ Vaginal/forceps
- □ Cesarean
- □ Other
- □ Not specified

- □ Artificial
- □ Spontaneous

**Multiple Gestation**:
- □ Yes
- □ No
- □ Not specified

**Pregnancy Outcome***:
- □ Livebirth (blank)
- □ Induced abortion
- □ Ectopic pregnancy
- □ Livebirth/stillbirth
- □ Other
- □ Not specified

### Vital Signs

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Temperature</th>
<th>Pulse</th>
<th>Respiration</th>
<th>BP Systolic</th>
<th>BP Diastolic</th>
</tr>
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</table>

**Highest BP**
- Systolic BP*: ______
- Diastolic BP*: ______
Birth Attendant(s)

<table>
<thead>
<tr>
<th>Title</th>
<th>Specify Other</th>
<th>NPI#</th>
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</table>

Title (dropdown options in grid above)
- □ MFM
- □ OBGYN
- □ Family practice
- □ Other MD/DO
- □ CNM
- □ NM
- □ Other
- □ Unknown
- □ Not specified

Were there complications of anesthesia?*
- □ Yes
- □ No
- □ Not specified

Anesthesia

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Method</th>
<th>Complications</th>
</tr>
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</table>

Were there adverse reactions to any medications?*
- □ Yes
- □ No
- □ Not specified

List of Medications

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Medication</th>
<th>Dose/Frequency/Duration</th>
<th>Adverse Reaction?</th>
</tr>
</thead>
<tbody>
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</table>

Were there any surgical procedures?*
- □ Yes
- □ No
- □ Not specified

Surgical Procedures

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Hospital Unit</th>
<th>Procedure</th>
<th>Performed By?</th>
<th>Outcome</th>
</tr>
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</tbody>
</table>

Were there any blood or blood product transfusions?*
- □ Yes
- □ No
- □ Not specified

Patient blood type: ______
### ER Visits and Hospitalizations cont.

#### Blood Products

<table>
<thead>
<tr>
<th>Date and time</th>
<th>Product</th>
<th>Number of Units</th>
<th>Reaction/Complications</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

#### Referrals and Consultations

<table>
<thead>
<tr>
<th>Date</th>
<th>Specialist type</th>
<th>Reason</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
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</table>


Reviewer's Notes about this Hospitalization, Delivery or ER Visit
Note: Fill out separate summary for each hospital visit and label each different facility by number or letter to differentiate facilities.

For this section, a sample entry could include:

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 ________________ abnormal findings noted. Diagnostic tests performed included _________________ with the following abnormal findings noted __________________. Her diagnosis was _______________ and she was admitted to ______________ (describe unit) OR transferred to ______________ OR discharged to _______________. (If admitted provide brief chronological synopsis of events that occurred during the hospital stay including condition and vital signs when discharged.) If admission to L&D complete the following template: She labored for _____________ hours and delivered via _______________ (method—if CS describe reason) by a (n) _______________ (provider type) under _______________ (anesthesia/local). Medications administered during labor and delivery or postpartum included _______________. She received __________ units of blood products (delete if not applicable). Infant weighed ______________ with Apgars of ______________. Complications during labor, delivery or postpartum (prior to discharge) include __________________. She was discharged home on day ____________. Vitals signs at discharge included ______________. She was instructed to _______________________________ (special education or f/up appointments).

List any other relevant notes.
Other Medical Office Visits

Visit Date of Medical Office Visit
Month: ______  Day: ______  Year: ______

□ Estimate  Gestational age - weeks: ______  Gestational age - days: ______  Days postpartum: ______

Visit type*:
□ Initial  □ Referral  □ Not specified
□ Annual  □ Post-partum
□ Follow-up  □ Other

Arrival time: ______
Medical record no.: ______
Reason for visit or chief complaint: ________________________

Medical Care Facility
Place Type:
□ Hospital  □ Office  □ Unknown
□ Clinic  □ Other  □ Not specified
Specify other place type: ________________________

Provider Type:
□ OBGYN  □ Mental health specialist  □ Treatment specialist
□ MFM  □ Pain management clinic  □ Other subspecialist
□ Family practice  □ Unknown
Specify other provider type: ________________________

Payment source:
□ Private  □ Self  □ Unknown
□ Public  □ Other  □ Not specified
Specify other payment source: ________________________

Pregnancy status:
□ Pregnant  □ Post-partum  □ Unknown
Was this provider her primary prenatal care provider?: ______

Location of Medical Care Facility
Street: ___________  State: ______  County: ______
City: ______  Zip Code: ______

Relevant Medical History
Finding  Comment(s)

Relevant Family History
Finding  Comment(s)
### Relevant Social History

<table>
<thead>
<tr>
<th>Finding</th>
<th>Comment(s)</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

### Vital Signs

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Temperature</th>
<th>Pulse</th>
<th>Respiration</th>
<th>BP Systolic</th>
<th>BP Diastolic</th>
</tr>
</thead>
<tbody>
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</table>

### Laboratory Tests

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Specimen</th>
<th>Test Name</th>
<th>Result</th>
<th>Diagnostic Level</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Diagnostic level (dropdown options in grid above)
- [ ] Within normal limits
- [ ] Markedly decreased
- [ ] Markedly increased
- [ ] Mildly decreased
- [ ] Mildly increased
- [ ] Not applicable
- [ ] Decreased
- [ ] Increased
- [ ] Not specified

### Diagnostic Imaging and Other Technology

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Technology type</th>
<th>Target/Procedure</th>
<th>Finding</th>
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<tbody>
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Technology type (dropdown options in grid above)
- [ ] CT
- [ ] CVS
- [ ] ECG
- [ ] EEG
- [ ] MRI
- [ ] PET
- [ ] US
- [ ] X-ray
- [ ] Other

### Physical Exam

<table>
<thead>
<tr>
<th>Body system</th>
<th>Finding</th>
<th>Comment(s)</th>
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Body system, (dropdown options in grid above)
- [ ] Constitutional
- [ ] Eyes
- [ ] Musculoskeletal
- [ ] Skin
- [ ] Ear/Nose/Throat
- [ ] Neurological
- [ ] Respiratory
- [ ] Endocrine
- [ ] Cardiovascular
- [ ] Psychiatric
- [ ] Gastrointestinal
- [ ] Genitourinary
- [ ] Immunologic
- [ ] Hematologic
- [ ] Other
### Other Medical Office Visits cont.

#### Referrals and Consultations

<table>
<thead>
<tr>
<th>Date</th>
<th>Specialty</th>
<th>Reason</th>
<th>Recommendations</th>
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#### Medications

<table>
<thead>
<tr>
<th>Date and time</th>
<th>Medication Name</th>
<th>Dose/Frequency/Duration</th>
<th>Adverse Reaction?</th>
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#### Visit Summary

<table>
<thead>
<tr>
<th>Abnormal Findings</th>
<th>Recommendations and Action Plans</th>
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**Reviewer’s Notes about This Medical Office Visit**
Medical Transport

Record: _____
Month: _____ Day: _____ Year: _____

□ Estimate

Gestational age - weeks: _____ Gestational age - days: _____ Days postpartum: _____

Reason for transport: ________________
Maternal conditions (describe): ________________
Who managed the transport?:
☐ Attending physician ☐ EMS/911
☐ Another clinician ☐ Other
Specify other: ________________

Transport Vehicle:
☐ Ground ambulance ☐ Helicopter
☐ Fixed-wing aircraft ☐ Other
Specify other: ________________

Timing of Transport
Call received: _____
Depart for patient origin: _____ Arrive at patient origin: _____
Patient contact: _____
Depart for referring facility: _____ Arrive at referring facility: _____

Origin Information
Place of origin:
☐ Home ☐ Hospital ☐ Other
If hospital chosen, enter trauma level of care:
☐ Level I ☐ Level III ☐ Other
☐ Level II ☐ Level IV
Specify other trauma level of care: ________________
If hospital chosen, enter maternal level of care:
☐ Birth center ☐ Subspecialty care (Level III)
☐ Basic care (Level I)
☐ Specialty care (Level II)
Specify other maternal level of care: ________________
Comments:
Procedures before transport (describe): ________________
Procedures during transport (describe): ________________

Transport Vital Signs

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>GA-Weeks</th>
<th>GA-Days</th>
<th>Systolic BP</th>
<th>Diastolic BP</th>
<th>Oxygen Saturation</th>
<th>Blood Sugar</th>
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Mental status of patient during transport (describe): ________________
Documented pertinent oral statements made by patient or others on scene: ________________
**Medicine Transport cont.**

**Destination Information**
Place of Destination: ________
Trauma Level of Care:
- [ ] Level I
- [ ] Level II
- [ ] Level III
- [ ] Level IV
- [ ] Other

Specify other trauma level of care: __________________________

Maternal Level of Care:
- [ ] Birth center
- [ ] Basic care (Level I)
- [ ] Specialty care (Level II)
- [ ] Subspecialty care (Level III)
- [ ] Regional perinatal health care center (Level IV)
- [ ] Other

Specify other maternal level of care: ______________________
Comments: ______________________

**Reviewer's Notes about Medical Transport**
Note: For this section, a sample entry could include:
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 place/level of care).

List any other relevant notes.
**Social and Environmental Profile**

### Socioeconomic Characteristics

**Source of income:**
- □ Self
- □ Spouse
- □ Relative
- □ Public assistance
- □ Other
- □ Not specified
- □ Unknown

**Employment status:**
- □ Full
- □ Part-time
- □ Self-employed
- □ Contract
- □ Unemployed
- □ Other
- □ Not specified
- □ Unknown

**Occupation:**

**Country of birth:**

**Immigration status:**
- □ Legal permanent resident (LPR)
- □ Refugee/asylee
- □ U.S. citizen
- □ Parolee
- □ Work visa holder (J and H)
- □ Student visa holder
- □ Tourist/visitor visa holder (Including laser visa border-crossers)
- □ Undocumented
- □ Victim of crime/victim of trafficking or unaccompanied minor
- □ Other
- □ Unknown

**Time in the U.S.:**

**Units:**
- □ Minute(s)
- □ Hour(s)
- □ Day(s)
- □ Week(s)
- □ Month(s)
- □ Year(s)

**Current living arrangements:**
- □ Own
- □ Rent
- □ Public housing
- □ Live with relative
- □ Homeless
- □ Other
- □ Unknown
- □ Not specified

**Homelessness**:  
- □ Never
- □ Yes, in last 12 months
- □ Yes, but more than 12 months ago
- □ Unknown
- □ Not specified

**Religious preference:**

### Members of Household

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Gender</th>
<th>Age</th>
<th>Comment(s)</th>
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</table>

**Gender (dropdown options in grid above):**
- □ Male
- □ Female
- □ Unknown
- □ Not specified

**Relationship (dropdown options in grid above):**
- □ Partner/spouse
- □ Child
- □ Parent
- □ Sibling
- □ Aunt/uncle
- □ Niece/nephew
- □ Grandparent
- □ Cousin
- □ Unknown
- □ Not specified

**Previous or Current Incarceration(s)?:**
- □ Never
- □ Before pregnancy
- □ During pregnancy
- □ After pregnancy
Details of Incarcerations

<table>
<thead>
<tr>
<th>Date</th>
<th>Duration</th>
<th>Reason</th>
<th>Comment(s)</th>
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</table>

Health Care Access
Documented barriers to health care access* (select all that apply):
- Child care
- Cultural norms
- Distance
- Financial
- Transportation
- Mobility

Comments: ________________

Communications
Documented barriers to communications* (select all that apply):
- Hearing impaired
- Functional illiteracy
- Speech impaired
- Language differences
- Vision impaired
- Cultural differences

Comments: ________________

Social or Emotional Stress
Evidence of social or emotional stress* (select all that apply):
- History of domestic violence
- History of psychiatric hospitalizations or treatment
- Child Protective Services involvement
- History of substance use treatment
- History of substance use
- History of childhood trauma
- Prior suicide attempts
- Other
- Pregnancy unwanted
- Recent trauma
- None

Specify other evidence of stress: ________________
Explain further: ________________

Utilization of Health Care System
- No prenatal care*

Reasons for missed appointments (select all that apply)*:
- Lack of childcare
- Appointment conflict
- No transportation
- Busy elsewhere
- Forgot
- Don't Like prenatal care provider
- Other

Specify other reason: ________________

Comments: ________________

Military status at time of death:
- Active military
- Military dependent
- Military veteran
- None of the above

Is there documentation of bereavement support?:
- Yes
- No

Comments: ________________

Is there documentation of bereavement support?:
- Yes
- No
- Unknown
### Social and Medical Referrals

<table>
<thead>
<tr>
<th>Date</th>
<th>Referred to</th>
<th>Specialty</th>
<th>Reason</th>
<th>Adhered?</th>
<th>Reason for Non-Adherence</th>
</tr>
</thead>
</table>

Adhered (dropdown options in grid above)
- ☐ Yes
- ☐ No
- ☐ Unknown

### Sources of Social Services Information for this Record

<table>
<thead>
<tr>
<th>Date</th>
<th>Element</th>
<th>Source Name</th>
<th>Comment(s)</th>
</tr>
</thead>
</table>

Element (dropdown options in grid above)
- ☐ SES characteristics
- ☐ Household members
- ☐ Incarcerations
- ☐ Barriers to health care
- ☐ Communication barriers
- ☐ Stress
- ☐ Utilization of health care
- ☐ Referrals
- ☐ Unknown

Was there documented substance use?*
- ☐ Yes
- ☐ No
- ☐ Unknown

If Yes, Specify Substance(s)

<table>
<thead>
<tr>
<th>Documented Substance</th>
<th>Timing of Substance Use</th>
</tr>
</thead>
</table>

Timing (dropdown options in grid above)
- ☐ No documentation
- ☐ During pregnancy
- ☐ Pre-pregnancy
- ☐ Postpartum

Substance (dropdown options in grid above)
- ☐ Acetaminophen
- ☐ Acetazolamide (Diamox)
- ☐ Alcohol
- ☐ Alprazolam (Xanax)
- ☐ Aripiprazole (Abilify)
- ☐ Aminoclonazepam
- ☐ Buprenorphine
- ☐ Carbamazepine (Neurontin)
- ☐ Chlor Diazepoxide (Librium)
- ☐ Citalopram (Celexa)
- ☐ Clonazepam (Klonopin or Rivotril)
- ☐ Cocaine
- ☐ Diazepam (Valium)
- ☐ Doxepin (Silenor, Zonalon, Prudoxin)
- ☐ Duloxetine (Cymbalta)
- ☐ Felbamate (Felbatol)
- ☐ Fentanyl
- ☐ Fluoxetine/Olanzapine (Symbyax)
- ☐ Heroin
- ☐ Hydromorphone (Dilaudid)
- ☐ Lorazepam (Ativan)
- ☐ Lurasidone (Latuda)
- ☐ Meprobamate (Equanil)
- ☐ Methadone
- ☐ Methadone Hydrochloride
- ☐ Midazolam (Versed)
- ☐ Morphine Sulfate
- ☐ Oxycodone Hydrochloride
- ☐ Oxymorphone Hydrochloride (Opana)
- ☐ Pregabalin (Lyrica)
- ☐ Quetiapine (Seroquel)
- ☐ Sertraline (Zoloft)
- ☐ Temazepam (Restoril)
- ☐ Trazadone (Oleptro)
- ☐ Zolpidem (Ambien)
Reviewer’s Notes about the Social and Environmental Profile
Mental Health Profile

Were there documented preexisting mental health conditions?*

- Yes
- No
- Unknown

**Documented Preexisting Mental Health Conditions**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Duration of Condition</th>
<th>Treatment</th>
<th>Duration of Treatment</th>
<th>Treatment changed during pregnancy</th>
<th>Dosage changed during pregnancy</th>
<th>If Yes, Mental Health Provider Consultation during this pregnancy</th>
<th>Did patient adhere to treatment</th>
</tr>
</thead>
</table>

Condition (dropdown options in grid above)

- Depression
- Psychotic disorder
- Anxiety disorder (i.e. PTSD or OCD)
- Bipolar disorder
- Substance use disorder

Treatment or dosage changed (dropdown options in grid above)

- Yes
- No
- Unknown

MH consultation and adherence (dropdown options in grid above)

- Yes
- No
- Unknown

**Were There Documented Screenings and Referrals for Mental Health Conditions?**

<table>
<thead>
<tr>
<th>Date of Screening</th>
<th>GA-Weeks</th>
<th>GA-Days</th>
<th>Days Postpartum</th>
<th>Screening Tool</th>
<th>Referral for Treatment</th>
</tr>
</thead>
</table>

Referral (dropdown options in grid above)

- Yes
- No
- Unknown

Screening tools (dropdown options in grid above)

- Generalized Anxiety Disorder (GAD-7)
- Primary Care PTSD Screen (PC-PTSD)
- Edinburgh Postnatal Depression Scale (EPDS)
- Postpartum Depression Screening Scale (PDSS)
- Patient Health Questionnaire (PHQ-9)
- Beck Depression Inventory (BDI)
- Beck Depression Inventory-II (BDI-II)
- Center for Epidemiologic Studies Depression Scale Revised (CESD-R)
- Zung Self-Rating Depression Scale (SDS)

Specify other screening tool(s): _______

Was the decedent TREATED for any of the following mental health conditions PRIOR TO the most recent pregnancy? (select all that apply)*:

- Depression
- Bipolar disorder
- Substance use disorder
- Anxiety disorder
- Psychotic disorder
- Other

Specify other: _______
Mental Health Profile cont.

Was the decedent TREATED for any of the following mental health conditions DURING the most recent pregnancy? (select all that apply)*:

☐ Depression
☐ Anxiety disorder
☐ Bipolar disorder
☐ Psychotic disorder
☐ Substance use disorder
☐ Other

Specify other: _______

Was the decedent TREATED for any of the following mental health conditions AFTER the most recent pregnancy? (select all that apply)*:

☐ Depression
☐ Anxiety disorder
☐ Bipolar disorder
☐ Psychotic disorder
☐ Substance use disorder
☐ Other

Specify other: _______

Reviewer’s Notes about the Mental Health Profile
Informant Interviews

Record: _____

Date of Interview
Month: ______
Day: ______ Year: ______

Interview type*:
☐ Family
☐ Neighbor
☐ Friend
☐ Witness

Informant name: ______

Age Group:
☐ 65 or older
☐ 18 to 64
☐ 12 to 18
☐ 6 to 11

Relationship to deceased:
☐ None
☐ Parent
☐ Grandparent

Other Relationship: ______

Ethnicity:
☐ No, not Spanish/Hispanic/Latino
☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino

Race:
☐ Black
☐ White
☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Islander
☐ Asian
☐ Biracial
☐ Multiracial

Interview Narrative

Page 40 of 47
Case Narrative

Note: For this section, input MMRIA data and run Core elements Report for data from multiple forms that are commonly used in MMRC analyses. The Core elements report is compiled to aid in developing the following Case narrative for presentation. A sample entry could include

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 ______________.

List any other relevant notes.
Committee Decisions

Note: Ensure that someone has been assigned responsibility for capturing, synthesizing and documenting committee decisions in MMRIA.

The Maternal Mortality Review Committee Decisions Form serves as a guide to ensure that your standard process addresses all key points needed to make six key decisions for each death reviewed:

1. Was the death pregnancy-related?
2. What was the cause of death?
3. Was the death preventable?
4. What were the critical contributing factors to the death?
5. What are the recommendations and actions that address those contributing factors?
6. What is the anticipated impact of those actions if implemented?

If available, the following additional information should be captured and included in case presentations to prompt reflection on these influences:

- Did obesity contribute to the death?
- Did mental health conditions contribute to the death?
- Did substance use disorder contribute to the death?
- Was the death a suicide?
- Was the death a homicide?
- If this death was a homicide, suicide, or accidental death, list the means of fatal injury.
- If this death was a homicide, what was the relationship of the perpetrator to the decedent?

The Maternal Mortality Review Information Application (MMRIA) is a comprehensive database that provides for standardized documentation of committee decisions. The MMRIA Committee Decisions Form may be printed and distributed with case review materials to facilitate committee discussion.
COMMITTEE DETERMINATION OF CAUSE(S) OF DEATH

<table>
<thead>
<tr>
<th>TYPE</th>
<th>CAUSE (DESCRIPTIVE)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IMMEDIATE

CONTRIBUTING

UNDERLYING

OTHER SIGNIFICANT

IF PREGNANCY-RELATED, COMMITTEE DETERMINATION OF UNDERLYING CAUSE OF DEATH
Refer to attached page for PMSS-MM cause of death list. If more than one is selected, list in order of importance beginning with the most compelling (1-2; no more than 2 may be selected in the system).

DID OBESITY CONTRIBUTE TO THE DEATH? □ YES □ PROBABLY □ NO □ UNKNOWN

DID MENTAL HEALTH CONDITIONS CONTRIBUTE TO THE DEATH? □ YES □ PROBABLY □ NO □ UNKNOWN

DID SUBSTANCE USE DISORDER CONTRIBUTE TO THE DEATH? □ YES □ PROBABLY □ NO □ UNKNOWN

WAS THIS DEATH A SUICIDE? □ YES □ NO

WAS THIS DEATH A HOMICIDE? □ YES □ NO

IF HOMICIDE, SUICIDE, OR ACCIDENTAL DEATH, LIST THE MEANS OF FATAL INJURY

□ FIREARM □ SHARP INSTRUMENT □ BLUNT INSTRUMENT □ POISONING/ OVERDOSE □ HANGING/ STRANGULATION/ SUFPROCATION

□ FALL PUNCHING/BEATING □ EXPLOSIVE □ DROWNING □ FIRE OR BURNS □ MOTOR VEHICLE

□ INTENTIONAL NEGLECT □ OTHER, SPECIFY: □ UNKNOWN


does committee agree with cause of death listed on death certificate? □ YES □ NO

If homicide, what was the relationship of the perpetrator to the decedent? □ NO RELATIONSHIP □ PARTNER □ EX-PARTNER □ OTHER RELATIVE

□ OTHER ACQUAINTANCE □ OTHER, SPECIFY: □ N/A □ UNKNOWN
**COMMITTEE DETERMINATION OF PREVENTABILITY**
A death is considered preventable if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, community, provider, facility, and/or systems factors.

<table>
<thead>
<tr>
<th>WAS THIS DEATH PREVENTABLE?</th>
<th>□ YES</th>
<th>□ NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHANCE TO ALTER OUTCOME?</td>
<td>□ GOOD CHANCE</td>
<td>□ SOME CHANCE</td>
</tr>
</tbody>
</table>

**CONTRIBUTING FACTORS WORKSHEET**
What were the contributing factors that contributed to this death? Multiple class categories may be assigned to each contributing factor.

**RECOMMENDATIONS OF THE COMMITTEE**
If there was at least some chance that the death could have been averted, what were the specific and feasible actions that, if implemented or altered, might have changed the course of events?

<table>
<thead>
<tr>
<th>CRITICAL FACTOR</th>
<th>CLASS CATEGORY AND DESCRIPTION OF ISSUE</th>
<th>RECOMMENDATIONS OF THE COMMITTEE</th>
<th>LEVEL OF PREVENTION (SELECT FROM MENU BELOW)</th>
<th>LEVEL OF IMPACT (SELECT FROM MENU BELOW)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT/FAMILY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMMUNITY</td>
<td></td>
<td></td>
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<tr>
<td>PROVIDER</td>
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<tr>
<td>FACILITY</td>
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<tr>
<td>SYSTEM</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**CLASS CATEGORY KEY (DEFINITIONS ON PAGE 4)**
- Delay
- Adherence
- Knowledge
- Cultural/religious
- Environmental
- Violence
- Mental health conditions
- Substance use disorders - alcohol, illicit/prescription drugs
- Tobacco use
- Chronic disease
- Childhood abuse/trauma
- Access/financial
- Unstable housing
- Social support/isolation
- Equipment/technology
- Policies/procedures
- Communication
- Continuity of care/care coordination
- Clinical skill/quality of care
- Outreach
- Enforcement
- Referral
- Assessment
- Legal
- Other

**PREVENTION**
- PRIMARY
  Prevents the contributing factor before it ever occurs
- SECONDARY
  Reduces the impact of the contributing factor once it has occurred (i.e. treatment)
- TERTIARY
  Reduces the impact or progression of an ongoing contributing factor once it has occurred (i.e. management of complications)

**EXPECTED IMPACT LEVEL**
- SMALL
  Education/counseling (community- and/or provider-based health promotion and education activities)
- MEDIUM
  Clinical intervention and coordination of care across continuum of care and visits through obstetrics (protocols, prescriptions)
- LARGE
  Long-lasting protective intervention (improve readiness, recognition and response to obstetric emergencies/LARC)
- EXTRA LARGE
  Change in context (promote environments that support healthy living/ensure accessible services)
- GIANT
  Address social determinants of health (poverty, inequality, etc.)
IF PREGNANCY-RELATED, COMMITTEE DETERMINATION OF UNDERLYING CAUSE OF DEATH* PMSS-MM
If more than one is selected, please list them in order of importance beginning with the most compelling (1-2; no more than 2 may be selected in the system).

*PREGNANCY-RELATED DEATH: THE DEATH OF A WOMAN DURING PREGNANCY OR WITHIN ONE YEAR OF THE END OF PREGNANCY FROM A PREGNANCY COMPLICATION, A CHAIN OF EVENTS INITIATED BY PREGNANCY, OR THE AGGRAVATION OF AN UNRELATED CONDITION BY THE PHYSIOLOGIC EFFECTS OF PREGNANCY.

<table>
<thead>
<tr>
<th></th>
<th>10</th>
<th>Hemorrhage (excludes aneurysms or CVA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td>Hemorrhage – rupture/laceration/Intra-abdominal bleeding</td>
<td></td>
</tr>
<tr>
<td>10.2</td>
<td>Placental abruption</td>
<td></td>
</tr>
<tr>
<td>10.3</td>
<td>Placenta previa</td>
<td></td>
</tr>
<tr>
<td>10.4</td>
<td>Ruptured ectopic pregnancy</td>
<td></td>
</tr>
<tr>
<td>10.5</td>
<td>Hemorrhage – uterine atony/postpartum hemorrhage</td>
<td></td>
</tr>
<tr>
<td>10.6</td>
<td>Placenta accreta/increta/percreta</td>
<td></td>
</tr>
<tr>
<td>10.7</td>
<td>Hemorrhage due to retained placenta</td>
<td></td>
</tr>
<tr>
<td>10.8</td>
<td>Hemorrhage due to primary DIC</td>
<td></td>
</tr>
<tr>
<td>10.9</td>
<td>Other hemorrhage/NOS</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Infection</td>
<td></td>
</tr>
<tr>
<td>20.1</td>
<td>Postpartum genital tract (e.g. of the uterus/pelvis/perineum/necrotizing fasciitis)</td>
<td></td>
</tr>
<tr>
<td>20.2</td>
<td>Septic/septic shock</td>
<td></td>
</tr>
<tr>
<td>20.4</td>
<td>Chorioamnionitis/antepartum infection</td>
<td></td>
</tr>
<tr>
<td>20.5</td>
<td>Non-pelvic infections (e.g. pneumonia, TB, meningitis, HIV)</td>
<td></td>
</tr>
<tr>
<td>20.6</td>
<td>Urinary tract infection</td>
<td></td>
</tr>
<tr>
<td>20.9</td>
<td>Other infections/NOS</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Embolism – thrombotic (non-cerebral)</td>
<td></td>
</tr>
<tr>
<td>30.9</td>
<td>Other embolism/NOS</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Embolism – amniotic fluid</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Preeclampsia</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Eclampsia</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Chronic hypertension with superimposed preeclampsia</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>Anesthesia complications</td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>Cardiomyopathy</td>
<td></td>
</tr>
<tr>
<td>80.1</td>
<td>Postpartum/peripartum cardiomyopathy</td>
<td></td>
</tr>
<tr>
<td>80.2</td>
<td>Hypertrophic cardiomyopathy</td>
<td></td>
</tr>
<tr>
<td>80.9</td>
<td>Other cardiomyopathy/NOS</td>
<td></td>
</tr>
<tr>
<td>82</td>
<td>Hematologic</td>
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<tr>
<td>82.1</td>
<td>Sickle cell anemia</td>
<td></td>
</tr>
<tr>
<td>82.9</td>
<td>Other hematologic conditions including thrombophilias/TTP/HUS/NOS</td>
<td></td>
</tr>
<tr>
<td>83</td>
<td>Collagen vascular/autoimmune diseases</td>
<td></td>
</tr>
<tr>
<td>83.1</td>
<td>Systemic lupus erythematosus (SLE)</td>
<td></td>
</tr>
<tr>
<td>83.9</td>
<td>Other collagen vascular diseases/NOS</td>
<td></td>
</tr>
<tr>
<td>85</td>
<td>Conditions unique to pregnancy (e.g. gestational diabetes, hyperemesis, liver disease of pregnancy)</td>
<td></td>
</tr>
<tr>
<td>88</td>
<td>Injury</td>
<td></td>
</tr>
<tr>
<td>88.1</td>
<td>Intentional (homicide)</td>
<td></td>
</tr>
<tr>
<td>88.2</td>
<td>Unintentional</td>
<td></td>
</tr>
<tr>
<td>88.9</td>
<td>Unknown/NOS</td>
<td></td>
</tr>
<tr>
<td>89</td>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>89.1</td>
<td>Gestational trophoblastic disease (GTD)</td>
<td></td>
</tr>
<tr>
<td>89.3</td>
<td>Malignant melanoma</td>
<td></td>
</tr>
<tr>
<td>89.9</td>
<td>Other malignancies/NOS</td>
<td></td>
</tr>
<tr>
<td>90</td>
<td>Cardiovascular conditions</td>
<td></td>
</tr>
<tr>
<td>90.1</td>
<td>Coronary artery disease/myocardial infarction (MI)/atherosclerotic cardiovascular disease</td>
<td></td>
</tr>
<tr>
<td>90.2</td>
<td>Pulmonary hypertension</td>
<td></td>
</tr>
<tr>
<td>90.3</td>
<td>Valvular heart disease congenital and acquired</td>
<td></td>
</tr>
<tr>
<td>90.4</td>
<td>Vascular aneurysm/dissection (non-cerebral)</td>
<td></td>
</tr>
<tr>
<td>90.5</td>
<td>Hypertensive cardiovascular disease</td>
<td></td>
</tr>
<tr>
<td>90.6</td>
<td>Marfan Syndrome</td>
<td></td>
</tr>
<tr>
<td>90.7</td>
<td>Conduction defects/arrhythmias</td>
<td></td>
</tr>
<tr>
<td>90.8</td>
<td>Vascular malformations outside head and coronary arteries</td>
<td></td>
</tr>
<tr>
<td>90.9</td>
<td>Other cardiovascular disease, including CHF, cardiomegaly, cardiac hypertrophy, cardiac fibrosis, nonacute myocarditis/NOS</td>
<td></td>
</tr>
<tr>
<td>91</td>
<td>Pulmonary conditions (excludes ARDS-Adult respiratory distress syndrome)</td>
<td></td>
</tr>
<tr>
<td>91.1</td>
<td>Chronic lung disease</td>
<td></td>
</tr>
<tr>
<td>91.2</td>
<td>Cystic fibrosis</td>
<td></td>
</tr>
<tr>
<td>91.3</td>
<td>Asthma</td>
<td></td>
</tr>
<tr>
<td>91.9</td>
<td>Other pulmonary disease/NOS</td>
<td></td>
</tr>
<tr>
<td>92</td>
<td>Neurologic/neurovascular conditions (excluding CVAs)</td>
<td></td>
</tr>
<tr>
<td>92.1</td>
<td>Epilepsy/seizure disorder</td>
<td></td>
</tr>
<tr>
<td>92.9</td>
<td>Other neurologic diseases/NOS</td>
<td></td>
</tr>
<tr>
<td>93</td>
<td>Renal disease</td>
<td></td>
</tr>
<tr>
<td>93.1</td>
<td>Chronic renal failure/End-stage renal disease (ESRD)</td>
<td></td>
</tr>
<tr>
<td>93.9</td>
<td>Other renal disease/NOS</td>
<td></td>
</tr>
<tr>
<td>95</td>
<td>Cerebrovascular accident (hemorrhage/thrombosis/aneurysm/malformation) not secondary to hypertensive disease</td>
<td></td>
</tr>
<tr>
<td>96</td>
<td>Metabolic/endocrine</td>
<td></td>
</tr>
<tr>
<td>96.1</td>
<td>Obesity</td>
<td></td>
</tr>
<tr>
<td>96.2</td>
<td>Diabetes mellitus</td>
<td></td>
</tr>
<tr>
<td>96.9</td>
<td>Other metabolic/endocrine disorders</td>
<td></td>
</tr>
<tr>
<td>97</td>
<td>Gastrointestinal disorders</td>
<td></td>
</tr>
<tr>
<td>97.1</td>
<td>Crohn's disease/ulcerative colitis</td>
<td></td>
</tr>
<tr>
<td>97.2</td>
<td>Liver disease/failure/transplant</td>
<td></td>
</tr>
<tr>
<td>97.9</td>
<td>Other gastrointestinal diseases/NOS</td>
<td></td>
</tr>
<tr>
<td>100</td>
<td>Mental health conditions</td>
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<tr>
<td>100.1</td>
<td>Depression</td>
<td></td>
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<tr>
<td>100.9</td>
<td>Other psychiatric conditions/NOS</td>
<td></td>
</tr>
<tr>
<td>999</td>
<td>Unknown COD</td>
<td></td>
</tr>
</tbody>
</table>
CLASS DESCRIPTIONS

DELAY OR FAILURE TO SEEK CARE
The woman was delayed in seeking or did not access care, treatment, or follow-up care/actions (e.g. missed appointment and did not reschedule).

ADHERENCE TO MEDICAL RECOMMENDATIONS
The woman did not accept medical advice (e.g. refused treatment for religious or other reasons or left the hospital against medical advice).

KNOWLEDGE - LACK OF KNOWLEDGE REGARDING IMPORTANCE OF EVENT OR OF TREATMENT OR FOLLOW-UP
The woman did not receive adequate education or lacked knowledge or understanding regarding the significance of a health event (e.g. shortness of breath as a trigger to seek immediate care) or lacked understanding about the need for treatment/follow-up after evaluation for a health event (e.g. needed to keep appointment for psychiatric referral after an ED visit for exacerbation of depression).

CULTURAL/RELIGIOUS, OR LANGUAGE FACTORS
Demonstration that any of these factors was either a barrier to care due to lack of understanding or led to refusal of therapy due to beliefs (or belief systems).

ENVIRONMENTAL FACTORS
Factors related to weather or terrain (e.g. the advent of a sudden storm leads to a motor vehicle accident).

VIOLENCE AND INTIMATE PARTNER VIOLENCE (IPV)
Physical or emotional abuse other than that perpetrated by intimate partner (e.g. family member or stranger); IPV; Physical or emotional abuse perpetrated by the woman’s current or former intimate partner.

MENTAL HEALTH CONDITIONS
The woman carried a diagnosis of a psychiatric disorder. This includes postpartum depression.

SUBSTANCE USE DISORDER – ALCOHOL, ILLICIT/PRESCRIPTION DRUGS
Substance use disorder is characterized by recurrent use of alcohol and/or drugs causing clinically and functionally significant impairment, such as health problems or disability. The committee may determine that substance use disorder contributed to the death when the disorder directly compromised a woman’s health status (e.g. acute methamphetamine intoxication exacerbated pregnancy-induced hypertension, or woman was more vulnerable to infections or medical conditions).

TOBACCO USE
Women’s use of tobacco directly compromised the woman’s health status (e.g. long-term smoking led to underlying chronic lung disease).

CHRONIC DISEASE
Occurrence of one or more significant pre-existing medical conditions (e.g. obesity, cardiovascular disease, or diabetes).

CHILDHOOD SEXUAL ABUSE/TRAUMA
Woman experienced rape, molestation, or other sexual exploitation during childhood plus persuasion, inducement, or coercion of a child to engage in sexually explicit conduct; or woman experienced physical or emotional abuse or violence other than that related to sexual abuse during childhood.

LACK OF ACCESS/FINANCIAL RESOURCES
System issues, e.g. lack or loss of healthcare insurance or other financial duress, as opposed to woman’s noncompliance impacted woman’s ability to care for herself (e.g. did not seek services because unable to miss work or afford postpartum visits after insurance expired). Other barriers to accessing care: insurance non-eligibility, provider shortage in woman’s geographical area, and lack of public transportation.

UNSTABLE HOUSING
Woman lived “on the street” or in a homeless shelter or lived in transitional or temporary circumstances with family or friends.

SOCIAL SUPPORT/ISOLATION – LACK OF FAMILY/FRIEND SUPPORT SYSTEM
Social support from family, partner, or friends was lacking, inadequate, and/or dysfunctional (e.g. domestic violence, no one to rely on to ensure appointments were kept).

INADEQUATE OR UNAVAILABLE EQUIPMENT/TECHNOLOGY
Equipment was missing, unavailable, or not functional, (e.g. absence of blood tubing connector).

LACK OF STANDARDIZED POLICIES/PROCEDURES
The facility lacked basic policies or infrastructure germane to the woman’s needs (e.g. response to high blood pressure or a lack of or outdated policy or protocol).

POOR COMMUNICATION/LACK OF CASE COORDINATION OR MANAGEMENT/ LACK OF CONTINUITY OF CARE (SYSTEM PERSPECTIVE)
Care was fragmented (i.e. uncoordinated or not comprehensive) among or between healthcare facilities or units, (e.g. records not available between inpatient and outpatient or among units within the hospital, such as Emergency Department and Labor and Delivery).

LACK OF CONTINUITY OF CARE
Care providers did not have access to woman’s complete records or did not communicate woman’s status sufficiently. Lack of continuity can be between prenatal, labor and delivery, and postpartum providers.

CLINICAL SKILL/QUALITY OF CARE
Personnel were not appropriately skilled for the situation or did not exercise clinical judgment consistent with current standards of care (e.g. error in the preparation or administration of medication or unavailability of translation services).

INADEQUATE COMMUNITY OUTREACH/RESOURCES
Lack of coordination between healthcare system and other outside agencies/organizations in the geographic/cultural area that work with maternal child health issues.

INADEQUATE LAW ENFORCEMENT RESPONSE
Law enforcement response was not in a timely manner or was not appropriate or thorough in scope.

LACK OF REFERRAL OR CONSULTATION
Specialists were not consulted or did not provide care; referrals to specialists were not made.

FAILURE TO SCREEN/INADEQUATE ASSESSMENT OF RISK
Factors placing the woman at risk for a poor clinical outcome recognized, and the woman was not transferred/transported to a provider able to give a higher level of care.

LEGAL
Legal considerations that impacted outcome.