MATERNAL DEATH* INFORMATION FORM
For Maternal Deaths in the Secondary and Tertiary Health Care Facilities

Serial number_____

Note: Where choices of answer are given, please tick (✓) the applicable response(s). There could be more than one response for some of the questions.

Name and Address of the facility providing information: _____

_____

Identification Number of Health Facility _____

Date of filling the form: _____

Form filled by: _____ _____
Name **Designation**

Information taken from _____ _____ _____
Patient's Records **Through Interviews** **Both**

If through interview, name of the person providing the information _____

Relationship of the information provider with the deceased mother _____

Type of Facility:

Teaching Tertiary Hospital / DHQ Hospital / THQ Hospital

Private Hospital (Secondary / Tertiary Teaching /Tertiary Non Teaching) Others_____

Qualifications of the person in-charge of the maternity unit / health facility

Midwife / LHV / Nurse-midwife

DGO / DRCOG / MRCOG / FRCOG

MBBS / MCPS / FCPS / MS

Others (specify) _____

Note: All the following questions are about the mother who died.

Registration number _____

Name _____ **Education** _____

Age: **Actual, If known**_____ **Estimated, if actual not known**_____

Ethnicity

Sindhi / Urdu Speaking / Punjabi /

Pathan / Bengali / Balochi /
Others _____

Husband _____ _____
Name Profession

Referral: **By Whom**

Self Referral / Dai /TBA/
LHW /LHV /Midwife/
Doctor

from Where

Home/ Private Health Facility
Government Health Facility
If government health facility what type
DHQ /THQ /RHC /BHU
MCHC/ Maternity Home
Others_____

_____
Name of Health Facility

*** Death of a woman during pregnancy,labour and within 6 weeks of delivery or abortion**

Date and time of arrival in the health facility _____

Was the patient alive on arrival in the health facility yes_____ No_____

If yes, Date and Time of death in the health facility _____

Status of pregnancy on admission

Pregnant / Delivered / Aborted /

Ectopic pregnancy / Hydatidiform Mole

Date and Time of Delivery /Abortion _____

Condition of the patient on admission

a. General
Conscious / Unconscious
Pallor / Fi ts

b. Pulse _____

c. Temperature _____

d. Blood Pressure _____

e. Respiration _____

Past Obstetrical History

Number of total previous pregnancies and their outcome _____

Term deliveries (37 and more completed weeks of gestation) _____
Preterm deliveries (28-37 weeks of gestation) _____
Living children _____
Stillbirths (28 weeks of gestation and above) _____
Early Neonatal Deaths (birth - 7 days of life) _____
Late Neonatal Deaths (8-28 days of life) _____
Abortions _____
Caesarean sections _____

Current Pregnancy

Received ante-natal check up _____ Yes _____ No

If "Yes", for what? Routine/Swelling/Bleeding/Headache/
Other (specify)_____

Total number of Antenatal Check-ups _____

Place of Check-ups

Home / Hospital / Nursing Home / Clinic of G.P /
Clinic of Qualified Midwife / LHV /
Others (Please write) _____

Check up by whom, irrespective of the place of check up

Dai / TBA / LHW / Midwife /
LHV / Nurse midwife / Doctor

Last antenatal check up _____ Date _____ By whom

Duration of present Pregnancy in weeks (if available)

a. By dates _____
b. By Clinical assessment _____
c. By ultra sound, if available _____
d. Could not be assessed _____

If pregnancy was terminated before 24 weeks (abortion, H. Mole, Ectopic pregnancy), were there any complications?

_____ Yes _____ No

If "Yes" what:

a. Sepsis _____
b. Hemorrhage _____
c. Other complications _____

In case of abortion (H. Mole), was it

Spontaneous _____ Induced _____

If Induced, how?

a. Oxytocin infusion _____
b. With prostaglandin _____
c. Dilatation and Evacuation _____
d. Vacuum aspiration _____
e. Foley's catheter + oxytocin _____
f. Others _____

Obstetrical Complications during present pregnancy

a. Abortion ___
b. Bleeding(APH) ___
c. Pregnancy induced Hypertension/ Eclampsia ___
d. Prolonged labour / Obstructed labour ___
e. Others (Please specify) _____

Associated Medical disorders during pregnancy, if any

a. Anemia, (Hemoglobin of 9 gm or less) _____
b. Hypertension _____
c. Heart disease _____
d. Diabetes Mellitus _____
e. Hepatitis _____
f. Any other _____ (Please specify)
g. Not applicable _____

Delivered _____ Yes _____ No

If delivered, place of delivery _____

Attendant at delivery

a. Relative _____
b. Dai _____
c. LHW _____
d. LHV _____
e. Midwife _____
f. Nurse midwife _____
g. Doctor _____
h. Any other person _____

Labour

a. **Started spontaneously** _____ Yes _____ No

b. **If induced, how?**

Medical induction using:

Prostaglandin _____

Oxytocin I/M I/V _____

Misoprostol (cytotec) oral / p/v _____

Surgical induction using

A.R.M. _____

Duration Of Labour	Hours	Minutes
1st stage	_____	_____
2nd stage	_____	_____
3rd stage	_____	_____

Mode of delivery

a. Spontaneous Vertex delivery _____

b. Abnormal vaginal delivery (Breech,, Face etc) _____

c. Forceps Delivery _____

d. Vacuum Extraction _____

e. Internal Version & Breech Extraction _____

f. Destructive operation e.g. craniotomy _____

g. Abdominal Surgery _____

If Abdominal Surgery

a. Caesarian Section

Elective _____

Emergency _____

b. Hysterotomy _____

c. Hysterectomy _____

d. Any other _____

Who performed the surgery?

Resident MO _____

WMO _____

PG trainee _____

Registrar _____

Consultant _____

Others _____

Type of anesthesia administered

1. Local _____
2. Spinal _____
3. Epidural _____
4. General _____

Qualifications of the anesthetist (please specify) _____

Complications (Please describe in as much detail as possible)

During labor (e.g. prolonged / Obstructed labor, fetal distress, ruptured uterus etc)

_____

_____

During delivery (Ruptured uterus, Inversion of uterus, retained placenta, post partum hemorrhage, shock)

_____

_____

Due to anesthesia (failed intubation, inhalation etc)

_____

_____

During Puerperium (Infection, Hemorrhage, Renal failure etc) _____

_____

Amount of blood loss (Estimated in cup full)

a. Before Delivery _____

b. During Delivery _____

c. After Delivery

Within two hours _____

Between two to six hours _____

Replacement of blood

a. Number of blood transfusion _____

b. Type of IV fluid used _____

c. Amount of IV fluids _____

Baby (outcome of this pregnancy)

a. Born alive _____

b. Stillbirth

Fresh death _____

Macerated _____

c. Sex _____

d. Birth weight _____

e. Early Neonatal death (Birth to 7 days) _____

Results of most recent diagnostic tests if available

a. Blood

Hb. _____
Blood group _____
Blood sugar _____

Bilirubin _____
Electrolytes etc _____
Coagulation profile _____

b. Urine _____

c. X-ray _____

d. Ultrasound _____

_____

CAUSE OF MATERNAL DEATH (Consensus of the health care providers in view of all the available information-please circle the number before the cause of death)

1. Haemorrhage
   - 1.1 Antepartum
   - 1.2 Postpartum
2. Puerperal Sepsis
3. Hypertensive diseases of pregnancy
4. Eclampsia
5. Obstructed Labour /Ruptured Uterus
6. Abortion
   - 6.1 Died of bleeding
   - 6.2 Died of infection

Others:

7. Ectopic Pregnancy
8. Anaesthetic Death
9. Anaemia
10. Cardiac Disease
11. Hepatitis
12. Malaria
13. Coincidental Death e.g. Road Traffic Accidents, Burns etc (specify)
14. Other (specify)_____

YOU ARE ALL FAMILIAR WITH THREE DELAYS MODEL

FIRST DELAY: In taking a decision for seeking next level of medical help because there is expected or actual danger to the mother and or baby's life. This normally occurs at the home or a small or not well equipped health facility or in both places.

SECOND DELAY: This occurs AFTER the need for appropriate medical help has been identified. Many factors contribute to this delay. These include, making arrangements for meeting the cost, suitable means of transportation and a male escort etc.

THIRD DELAY: This occurs AFTER the woman has reached the appropriate health facility but could not get appropriate treatment to save her life. The reasons are many for delay at this level. These range between non-availability of resources and slow speed of action by the care providers.

For the Maternal Death under review was there delay at any stage which could have contributed to the death of this women?

Was there any delay in taking the decision to seek help? Yes No

If yes, What were the reasons

_____

_____

Was there any delay in reaching the facility? Yes No

If yes, what were the reasons?

_____

_____

Was there any delay in getting the required treatment? Yes No

If yes, what were the reasons?

_____

_____

_____

Name and Signature of the person filling the enquiry form

Date:_____

REMARKS AND SUMMARY OF THE CASE (To be filled by the consultant / doctor in charge of the unit)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature

_____

Name in block letters

Date: _____