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User name:   
Password:

Welcome to MMRIA



Form Approved  
OMB No. XXX-XXX  
Exp. Date XX/XX/XXX

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### Line Listing Summary

[ADD NEW CASE](#)

#### Search and Sort Case Listings

Search Text:

==>

[CLEAR SEARCH TEXT](#)

Sort By:

Sort Descending

Records per page:

Public reporting burden of this collection of information is estimated to average 15 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-xxxx)

Page: 1 of 1

Total Number of Records: 56

Select Page: [1](#) |

Case Information  
/ :true, is-artificial

Case Listing

Last Updated

Actions

migration\_plan 2019-03-13T01:58:07.761186Z press twice to delete ==>

[DELETE](#)

Home Summary **Case Forms** Print Version

### Home Record

new-last-name

First Name

new-first-name

Middle Name

Last Name

new-last-name

Date of Death\*

- Home Record
- Death Certificate
- Birth/Fetal Death Certificate- Parent Section
- Birth/Fetal Death Certificate- Infant/Fetal Section
- Autopsy Report
- Prenatal Care Record
- ER Visits and Hospitalizations
- Other Medical Office Visits
- Medical Transport
- Social and Environmental Profile
- Mental Health Profile
- Informant Interviews
- Case Narrative
- Committee Decisions

Home Summary **Case Forms** Print Version

### Home Record

**UNDO** **SAVE**

new-last-name, new-first-name

First Name

new-first-name

Middle Name

Last Name

new-last-name

Date of Death\*

Month

▼

Day

▼

Year

▼

State of Death Record\*

▼

Record ID\*

# Home Record

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Home Summary Case Forms Print Version

Home Record **UNDO** **SAVE**

new-last-name, new-first-name

First Name

Middle Name

Last Name

Date of Death\*

Month

Day

Year

State of Death Record\*

Record ID\*

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Home Summary Case Forms Print Version

Record ID\*

Agency-Based Case Identifier

How was this Death Identified? (Primary Source)\*

Specify Other or Additional Sources

Primary Abstractor

Jurisdiction ID /

Case Progress Report

Death Certificate

Autopsy Report

Birth/Fetal Death Certificate- Parent Section

Birth/Fetal Death Certificate- Infant/Fetal Section

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Prenatal Care Record

ER Visits and Hospitalizations

Other Medical Office Visits

Medical Transport

Social and Environmental Profile

Mental Health Profile

Informant Interviews

Case Narrative

Committee Decisions

**UNDO**

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# Birth/Fetal Death Certificate – Parent Section

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Home Summary Case Forms Print Version

Birth/Fetal Death Certificate- Parent Section **UNDO** **SAVE**

new-last-name, new-first-name

Facility of Delivery Demographics

Type of Place\*

Was Home Delivery Planned?

Date of Delivery

Month

Day

Year\*

Maternal Level of Care\*

Specify Other Maternal Level of Care

Facility NPI Number

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Facility NPI Number

Facility Name

Attendant's Title\*

Specify Other Title

Attendant's NPI

Was Mother Transferred?

If Yes, Enter Name of Facility Mother Transferred From

Facility of Delivery Location

Street

Apartment or Unit Number

City

Home Summary Case Forms Print Version

State\*

Zip Code

County

GET COORDINATES CLEAR

Matching geography type

Census tract certainty code

Census tract certainty name

Urban status

Father's Demographics

Date of Birth

Month

Year

Home Summary Case Forms Print Version

Father's Demographics

Date of Birth

Month

Year

Age

Father's Education

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 Minors/Orphan?

[Home](#) [Summary](#) [Case Forms](#) [Print Version](#)

Father of Hispanic Origin?

**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
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Other Race
- Race Not Specified

Specify Other Race

Specify Other Asian

Specify Other Pacific Islander

Specify Principal Tribe

[Home](#) [Summary](#) [Case Forms](#) [Print Version](#)

Specify Principal Tribe

**RECODE** **CLEAR**

Father's OMB Race Recode

**Maternal Record Identification**

First Name

Middle Name

Last Name

Maiden Name

Medical Record Number

**Mother's Demographics**

Date of Birth

Month

Day



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Home Summary Case Forms Print Version

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**Mother's Demographics**

**Date of Birth**

Month

Day

Year

Age\*

Mother Married?\*

If Mother Not Married, has Paternity Acknowledgement been Signed in the Hospital?

Mother's City of Birth

Mother's State of Birth (US)

Mother's Country of Birth (if Foreign Born)\*

Maternal Mortality Review Inform... x +

Not secure | test.mmria.org/Case#/4/birth\_fetal\_death\_certificate\_parent

Copy

Login | ADP Workfo... Virtual EMS MMRIA User Meeti...

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Primary Occupation

Business/Industry

Ever in U.S. Armed Forces?

Mother of Hispanic Origin?\*

Education\*

**Location of Residence**

Street

Apartment or Unit Number

City

State\*

Zip Code

Windows taskbar: 11:43 AM 4/1/2019

Home Summary Case Forms Print Version

Zip Code

County

**GET COORDINATES** **CLEAR**

Matching geography type

Census tract certainty code

Census tract certainty name

Urban status

**CALCULATED DISTANCE** **CLEAR**

Estimated Distance from Residence to Place of Delivery\* (In Miles)

Mother's Race

Mother's Race (Select All That Apply)\*

- White
- Black
- American Indian/Alaska Native
- Native Hawaiian
- Guamanian or Chamorro

Home Summary Case Forms Print Version

Mother's Race

Mother's Race (Select All That Apply)\*

- White
- Black
- American Indian/Alaska Native
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Other Race
- Race Not Specified

Specify Other Race

Specify Other Asian

Specify Other Pacific Islander

Specify Principal Tribe

**RECODE** **CLEAR**

Mother's OMB Race Recode

Home Summary Case Forms Print Version

RECODE CLEAR

Mother's OMB Race Recode

Pregnancy History

Date of Last Live Birth

Month

Day

Year

Live Birth Interval (Months)

Number of Previous Live Births (Do Not Include this Child)\*

Now Living

Now Dead

Number of Other Pregnancy Outcomes\*

Home Summary Case Forms Print Version

Number of Other Pregnancy Outcomes\*

Date of Last Other Pregnancy Outcome

Month

Day

Year

Pregnancy Interval (Months)

Maternal Biometrics

Height (Feet)

Height (Inches)

Pre-Pregnancy Weight (lbs.)

Weight at Delivery (lbs.)

Home Summary Case Forms Print Version

Weight Gain during Pregnancy (lbs.)

Pre-Pregnancy BMI\*

Prenatal Care

Date Last Normal Menses Began

Month

Day

Year

Date of First Prenatal Care Visit

Month

Day

Year

Date of Last Prenatal Care Visit

Home Summary Case Forms Print Version

Date of Last Prenatal Care Visit

Month

Day

Year

Calculated Gestation at Birth- Weeks

Calculated Gestation at Birth- Days

Obstetric Estimate of Gestation at Birth (Completed Weeks)\*

Plurality\*

Specify, if > 3

Did Mother get WIC Food for Herself During this Pregnancy?\*

Principal Source of Payment for this Delivery\*

Home Summary Case Forms Print Version

Principal Source of Payment for this Delivery\*

Specify Other

Trimester of First Prenatal Care Visit\*

Total Number of Prenatal Visits for this Pregnancy

### Cigarette Smoking Before and During Pregnancy

Three Months Before Pregnancy (# of Cigarettes/Packs)

Unit(s)

First Three Months of Pregnancy (# of cigarettes/packs)

Unit(s)

Second Three Months of Pregnancy (# of Cigarettes/Packs)

Unit(s)

Home Summary Case Forms Print Version

Unit(s)

Third Trimester of Pregnancy (# of Cigarettes/Packs)

Unit(s)

None or Not Specified

### Maternal Risk Factors

Risk Factors in this Pregnancy\*

- Prepregnancy Diabetes
- Gestational Diabetes
- Prepregnancy Hypertension
- Gestational Hypertension
- Eclampsia Hypertension
- Previous Preterm Birth
- Other Previous Poor Outcome
- 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))
- Mother had a Previous Cesarean Delivery
- None of These
- Not Specified

Number of C-sections

Home Summary Case Forms Print Version

Infections Present or Treated During this Pregnancy\*

- Hepatitis B (live birth only)
- Hepatitis C (live birth only)
- Gonorrhea
- Syphilis
- Listeria
- Cytomegalovirus
- Chlamydia
- Parvovirus
- Group B Streptococcus (fetal death(s) only)
- Toxoplasmosis (fetal death(s) only)
- None of These
- Not Specified

Onset of Labor (Choose All That Apply)\*

- Premature Rupture of Membranes (Prolonged)
- Prolonged labor (> 20 hours)
- Precipitous labor (< 3 hours)
- None of These
- Not Specified

Obstetric Procedures (Select All that Apply)\*

- Cervical Cerclage
- Tocolysis
- External Cephalic Version: Successful
- External Cephalic Version: Failed
- None of these
- Not specified

Characteristics of Labor and Delivery (Select All That Apply)\*

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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
- 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
- None of these
- Not specified

Maternal Morbidity (Select All That Apply)\*

- Maternal transfusion
- Unplanned hysterectomy
- Unplanned operating room procedure following delivery
- Third or fourth degree perineal laceration
- Admission to intensive care unit
- Ruptured uterus
- None of these
- Not specified

**CALCULATE LENGTH OF TIME** **CLEAR**

Number of Days Between Birth of Child and Death of Mother\*

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

[Home](#) [Summary](#) [Case Forms](#) [Print Version](#)

- Augmentation of labor
- 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
- None of these
- Not specified

Maternal Morbidity (Select All That Apply):

- Maternal transfusion
- Unplanned hysterectomy
- Unplanned operating room procedure following delivery
- Third or fourth degree perineal laceration
- Admission to intensive care unit
- Ruptured uterus
- None of these
- Not specified

**CALCULATE LENGTH OF TIME** **CLEAR**

Number of Days Between Birth of Child and Death of Mother\*


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

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# Birth/Fetal Death Certificate- Infant/Fetal Section

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Home Summary Case Forms Print Version

### Birth/Fetal Death Certificate- Infant/Fetal Section **UNDO** **SAVE**

record: 1

new-last-name, new-first-name

Record Type\*

Multiple Gestation

Birth Order

#### Newborn (Fetus) Record Identification


State File No.

Local File No.

Newborn Medical Record No.

Date of Delivery

Time of Delivery

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#### Newborn (Fetus) Biometrics and Demographics

##### Birth Weight

Unit of Measurement

Value (Grams or Pounds)\*

Value (Ounces)\*

Gender

##### Apgar Scores

5 Minute

10 Minute

Is Infant Living at Time of Report?

Is Infant Being Breastfed at Discharge?

Was Infant Transferred Within 24 Hours of Delivery?

Home Summary Case Forms Print Version

Was Infant Transferred Within 24 Hours of Delivery?

Specify Facility, City and State

Method of Delivery

A. Was Delivery With Forceps Attempted but Unsuccessful?

B. Was Delivery With Vacuum Extraction Attempted but Unsuccessful?

C. Fetal Presentation at Birth

Other Presentation

D. Final Route and Method of Delivery\*

If Cesarean, was a Trial of Labor Attempted?

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

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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 dwarfing syndromes)  
Cleft Lip with or without Cleft Palate  
Downs Syndrome  
Karyotype confirmed - Downs Syndrome  
Karyotype pending - Downs Syndrome  
Hypospadias  
Meningocele or Spina bifida  
Congenital diaphragmatic hernia  
Gastroschisis  
Cleft palate alone  
Suspected chromosomal disorder  
Karyotype confirmed - Suspected chromosomal disorder  
Karyotype pending - Suspected chromosomal disorder  
Congenital anomalies not specified  
None of the above

ICD Version

Home Summary Case Forms Print Version

- Downs Syndrome
- Karyotype confirmed - Downs Syndrome
- Karyotype pending - Downs Syndrome
- Hypoplasia
- Meningocele or Spina bifida
- Congenital diaphragmatic hernia
- Gastroschisis
- Cleft palate alone
- Suspected chromosomal disorder
- Karyotype confirmed - Suspected chromosomal disorder
- Karyotype pending - Suspected chromosomal disorder
- Congenital anomalies not specified
- None of the above

ICD Version

Causes of Fetal Death

Type	Class	Complication Subclass	Other (Specify)	ICD Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<b>DELETE</b>
					<b>ADD ITEM</b>

Reviewer's Notes About the Birth Certificate- Infant/Fetal Section

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# Autopsy Report

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## Autopsy Report **UNDO** **SAVE**

new-last-name, new-first-name

Was an Autopsy Performed?

Completeness of Autopsy Information\*

### Reporter Characteristics

Reporter Type

Other (Specify)

### Date of Autopsy

Month

Day

Year

Jurisdiction

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Jurisdiction

### Biometrics

#### Mother

#### Height

Feet

Inches

Weight (lbs)

BMI\*

#### Fetus (if applicable)

Fetal Weight (grams)

Fetal Length (inches)

Estimate of Gestational Age (Weeks)

*Clinicians Delivered to Maternal Death*

Home Summary Case Forms Print Version

Findings Relevant to Maternal Death

Gross Findings

Finding	Comment(s)	
<input type="text"/>	<input type="text"/>	DELETE
ADD ITEM		

Microscopic Findings

Finding	Comment(s)	
<input type="text"/>	<input type="text"/>	DELETE
ADD ITEM		

Was Toxicology Positive for Drugs?\*

Toxicology\*

Substance	Concentration	Unit of Measure	Level	Comment(s)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DELETE
ADD ITEM					

ICD Code Version

Home Summary Case Forms Print Version

Was Toxicology Positive for Drugs?\*

Toxicology\*

Substance	Concentration	Unit of Measure	Level	Comment(s)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DELETE
ADD ITEM					

ICD Code Version

Coroner/Medical Examiner Causes of Death


Type	Cause	ICD Code	Comment(s)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DELETE
ADD ITEM				

Reviewer's Notes About the Autopsy Report

Terminal Event / Autopsy Narrative Summary:  
(Briefly describe in chronological fashion the events immediately preceding the terminal event. Include critical symptoms.)

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# Prenatal Care Record

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## Prenatal Care Record **UNDO** **SAVE**

new-last-name, new-first-name

Prenatal Care Record No.

Was There More than One Prenatal Care Source?

### Primary Prenatal Care Facility

Place Type

Specify Other Place Type


Primary Provider Type

Specify Other Provider Type

Principal Source of Payment\*

Specify Other

Use of WIC\*

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Use of WIC\*

### Location of Primary Prenatal Care Facility

Street

Apartment or Unit Number

City

State\*

Zip Code

County

**GET COORDINATES** **CLEAR**

Matching geography type

Census tract certainty code

Census tract certainty name

Home Summary Case Forms Print Version

Census tract certainty name

Urban status

Prior Surgical Procedures Before this Pregnancy

Date Procedure Comment(s)

DELETE

ADD ITEM

Were There Documented Preexisting Medical Conditions?\*

Pre-existing Conditions

Other (Specify)

Duration

Comment(s)

DELETE

ADD ITEM

Were There Documented Mental Health Conditions?\*

Family Medical History

Relation

Condition

Living?

Age at Death

Comment(s)

DELETE

ADD ITEM

Was There Evidence of Substance Use?

Home Summary Case Forms Print Version

Was There Evidence of Substance Use?

Evidence of Substance Use

Screening

Counseling/Education

Comment(s)

DELETE

Specify Other

ADD ITEM

Pregnancy History

Gravida\*

Para\*

Abortions\*

Specify Details Below:

Date Ended

Outcome

Gestational Age- WeeksBirth weight (grams)

Method of Delivery

Complication(s)

Now Living?

DELETE

ADD ITEM

Intendedness (Current Pregnancy)

Was Pregnancy Planned?

Intendedness (Current Pregnancy)

Was Pregnancy Planned?

Was Patient Using Birth Control?

Date Birth Control was Discontinued

Month

Day

Year

Infertility Treatment (Current Pregnancy)

Did this Pregnancy Result from Infertility Treatment?\*

Fertility Enhancing Drugs

Assisted Reproductive Technology (ART)

ART Type

ART Type

Specify Other ART Type

Cycle Number

Embryos Transferred

Embryos Growing

Current Pregnancy

Date of Last Normal Menses\*

Month

Day

Year

Estimated Date of Confinement (Estimated Date of Delivery)

Month



Estimated Date of Confinement (Estimated Date of Delivery)

Month

Day

Year

Estimate based on

Date of First Prenatal Visit\*

Month

Day

Year

Gestational Age at First Prenatal Visit - Weeks

Gestational Age at First Prenatal Visit - Days

Gestational Age at First Prenatal Visit - Days

Date of First Ultrasound

Month

Day

Year

Gestational Age from First Ultrasound- Weeks

Gestational Age from First Ultrasound- Days

Date of Last Prenatal Visit

Month

Day

Year

Gestational Age at Last Prenatal Visit - Weeks

Home Summary Case Forms Print Version

Gestational Age at Last Prenatal Visit - Weeks

Gestational Age at Last Prenatal Visit - Days

Height\*

Feet

Inches

Pre-Pregnancy Weight (lbs)\*

BMI\*

Weight at First Visit (lbs)\*

Weight at Last Visit (lbs)\*

Weight Gain (lbs)\*

Total Number of Prenatal Care Visits\*

Home Summary Case Forms Print Version

Trimester of First Prenatal Care Visit\*

Number of Fetuses

Was Home Delivery Planned?

Attended Prenatal Care Visits Alone\*\*

Name, City and State of Intended Birthing Facility

Routine Monitoring

Date	GA- Weeks	GA- Days	Systolic BP	Diastolic BP	Urine Protein	Urine Ketones	Urine Glucose	Blood Hematocrit (%)	Weight (lbs)
------	-----------	----------	-------------	--------------	---------------	---------------	---------------	----------------------	--------------

DELETE

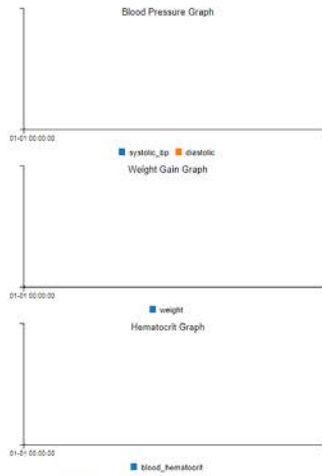
ADD ITEM

Blood Pressure Graph



Home Summary Case Forms Print Version

ADD ITEM



Home Summary Case Forms Print Version

Highest Blood Pressure\*

Systolic:   
 Diastolic:   
 Lowest Hematocrit\*:

Other Laboratory Tests

Date	GA- Weeks	GA- Days	Test/Procedure	Results (units)	Comment(s)	
2019-03-26	32	3	<input type="text"/>	<input type="text"/>	<input type="text"/>	DELETE
ADD ITEM						

Diagnostic Procedures

Date	GA- Weeks	GA- Days	Procedure	Comment(s)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DELETE
ADD ITEM					

Were There Problems Identified During the Current Pregnancy?\*

Specify Details Below

Date First Noted	GA- Weeks	GA- Days	Problem	Comment(s)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DELETE
ADD ITEM					

Home Summary Case Forms Print Version

ADD ITEM

Were There Any Adverse Reactions?\*

List of Medications/Drugs During Pregnancy

Date	GA- Weeks	GA- Days	Medication	Dose / Frequency / Duration	Reason	Adverse Reactions?*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DELETE

ADD ITEM

Were There Pre-Delivery Hospitalizations or ER Visits?\*

Pre-Delivery Hospitalizations Details

Date	GA- Weeks	GA- Days	Facility	Duration	Reason	Comments
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DELETE

ADD ITEM

Were There Referrals to Other Medical Specialists/Subspecialties?\*

Medical Referral Details

Date	GA- Weeks	GA- Days	Type of Specialist	Reason	Appointment Kept?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DELETE

ADD ITEM

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

Place	Provider Type	City	State	Begin Date	End Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Home Summary Case Forms Print Version

Date	GA- Weeks	GA- Days	Medication	Dose / Frequency / Duration	Reason	Adverse Reactions?*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DELETE

ADD ITEM

Were There Referrals to Other Medical Specialists/Subspecialties?\*

Medical Referral Details

Date	GA- Weeks	GA- Days	Type of Specialist	Reason	Appointment Kept?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DELETE

ADD ITEM

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

Place	Provider Type	City	State	Begin Date	End Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DELETE

ADD ITEM

Reviewer's Notes About the Prenatal Care Records


Prenatal Care Record: Narrative  
Summary Template

She was a gravida \_\_\_ para \_\_\_ with a past  
obstetric history of \_\_\_

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# ER Visits and Hospitalizations

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Home Summary Case Forms Print Version

## ER Visits and Hospitalizations **UNDO** **SAVE**

record: 1

new-last-name, new-first-name

### Maternal Record Identification

First Name

Middle Name

Last Name

Maiden Name


Medical Record Number

### Basic Admission and Discharge Information

Date of Arrival at Hospital/ER

Month

Day

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Home Summary Case Forms Print Version

Day

Year

Time of Arrival

Gestational Age- Weeks

Gestational Age- Days

Days Postpartum

### Date of Admission to Hospital

Month

Day

Year

Time of Admission

[Home](#) [Summary](#) [Case Forms](#) [Print Version](#)

Gestational Age- Weeks

Gestational Age- Days

Days Postpartum

Admission Condition

Admission Status

Specify Other Status

Admission Reason\*

Specify Other Reason

Was Mother Received from Another Hospital?

From Where?

Was Mother Transferred to Another Hospital?

[Home](#) [Summary](#) [Case Forms](#) [Print Version](#)

Was Mother Transferred to Another Hospital?

To Where?

Date of Discharge from ER/Hospital

Month

Day

Year

Time of Discharge

Gestational Age- Weeks

Gestational Age- Days

Days Postpartum

Discharge Pregnancy Status\*

[Home](#) [Summary](#) [Case Forms](#) [Print Version](#)

Discharge Pregnancy Status\*

Deceased at Time of Discharge?\*

Name and Location of Facility

Facility Name

Type of Facility\*

Facility NPI Number

Maternal Level of Care\*

Specify Other Maternal Level of Care

Street

Apartment or Unit Number

City

[Home](#) [Summary](#) [Case Forms](#) [Print Version](#)

State

Zip Code

County

**GET COORDINATES** **CLEAR**

Matching geography type

Census tract certainty code

Census tract certainty name

Urban status

Mode of Transportation to Facility

Specify Other Mode of Transportation

Origin of Travel

Specify Other Origin

Home Summary Case Forms Print Version

Specify Other Origin

Travel Time to Hospital

Value

Unit

Internal Transfers

Date and Time

From Unit

To Unit

Comments)

DELETE

ADD ITEM

Maternal Biometrics

Admission Weight (lbs)

Height

Feet

Inches

Home Summary Case Forms Print Version

Inches

BMI

Physical Examinations and Evaluations

Date and Time

Exam/Evaluation

Findings

Performed By?

DELETE

ADD ITEM

Psychological Examinations and Assessments

Date and Time

Exam/Assessment

Findings

Performed By?

DELETE

ADD ITEM

Laboratory Tests

Date and Time

Specimen

Test Name

Result

Diagnostic Level

Flag

Markedly Increased

DELETE

Mildly Increased

DELETE

DELETE

ADD ITEM

Pathology

Date and Time

Specimen

Exam Type

Findings



ADD ITEM

Pathology	Specimen	Exam Type	Findings
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DELETE

ADD ITEM

Onset of Labor

Date of Onset of Labor

Month

Day

Year

Time of Onset of Labor:

CALCULATE DURATION CLEAR

Duration of Labor Prior to Arrival (hrs)

Date of Rupture of Membranes

Month

Date of Rupture of Membranes

Month

Day

Year

Time of Rupture:

Final Delivery Route\*

Onset of labor was

Multiple Gestation

Pregnancy Outcome\*

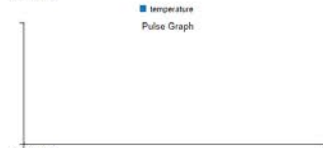
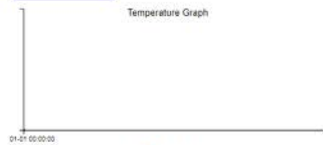
Vital Signs	Temperature	Pulse	Respiration	BP Systolic	BP Diastolic
Date and Time	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DELETE

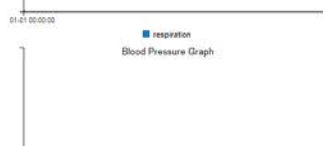
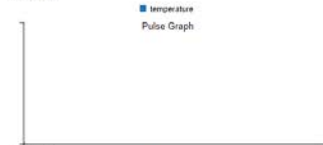
### Highest BP

Systolic BP\*

Diastolic BP\*



01-21 00:00:00



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■ bp\_systolic ■ bp\_diastolic

Birth Attendant(s)

Title	Specify Other	NPI#	
<input type="text"/>	<input type="text"/>	<input type="text"/>	DELETE
			ADD ITEM

Were There Complications of Anesthesia?\*

Anesthesia Date and Time	Method	Complications	
<input type="text"/>	<input type="text"/>	<input type="text"/>	DELETE
			ADD ITEM

Were There Adverse Reactions to Any Medications?\*

List of Medications Date and Time	Medication	Dose/Frequency/Duration	Adverse Reaction?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DELETE
				ADD ITEM

Were There Any Surgical Procedures?\*

Surgical Procedures Date and Time	Hospital Unit	Procedure	Performed By?	Outcome	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DELETE
					ADD ITEM

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Surgical Procedures

Date and Time	Hospital Unit	Procedure	Performed By?	Outcome	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DELETE
					ADD ITEM

Were There Any Blood or Blood Product Transfusions?\*

Blood Products Date and Time	Product	Number of Units	Reaction/Complications	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DELETE
				ADD ITEM

Diagnostic Imaging and Other Technology

Date and Time	Procedure	Target	Findings	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DELETE
				ADD ITEM

Referrals and Consultations

Date	Specialist Type	Reason	Recommendations	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DELETE
				ADD ITEM

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...

Blood Products	Product	Number of Units	Reaction/Complications
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			<b>DELETE</b>
			<b>ADD ITEM</b>

Diagnostic Imaging and Other Technology	Procedure	Target	Findings
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			<b>DELETE</b>
			<b>ADD ITEM</b>

Referrals and Consultations	Specialist Type	Reason	Recommendations
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			<b>DELETE</b>
			<b>ADD ITEM</b>

Reviewer's Notes About this Hospitalization, Delivery or ER Visit

[Fill out separate summary for each hospital visit and label each different facility by number or letter to differentiate facilities.]

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## Other Medical Office Visits

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Other Medical Office Visits **UNDO** **SAVE**

record: 1

new-last-name, new-first-name

Visit

Date Of Medical Office Visit

Months

Day

Year

Arrival Time

Gestational Age- Weeks

Gestational Age- Days

Days Postpartum

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Visit Type\*

Medical Record No

Reason For Visit Or Chief Complaint

Medical Care Facility

Place Type

Specify Other Place Type

Provider Type

Specify Other Provider Type

Payment Source

Specify Other

Pregnancy Status

Home Summary Case Forms Print Version

Was This Provider Her Primary Prenatal Care Provider?\*

Location Of Medical Care Facility

Street

Apartment or Unit Number

City

State

Zip Code

County

GET COORDINATES CLEAR

Matching geography type

Census tract certainty code

Census tract certainty name

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Census tract certainty code

Census tract certainty name

Urban status

Relevant Medical History Finding

Comment(s)

**DELETE**

**ADD ITEM**

Relevant Family History Finding

Comment(s)

**DELETE**

**ADD ITEM**

Relevant Social History Finding

Comment(s)

**DELETE**

Home Summary Case Forms **Print Version**

Census tract certainty code

Census tract certainty name

Urban status

Relevant Medical History Finding

Comment(s)

**DELETE**

**ADD ITEM**

Relevant Family History Finding

Comment(s)

**DELETE**

**ADD ITEM**

Relevant Social History Finding

Comment(s)

**DELETE**

**ADD ITEM**

**Referrals and Consultations**

Date	Specialty	Reason	Recommendations
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**DELETE**

**ADD ITEM**

**Medications**

Date and Time	Medication Name	Dose/Frequency/Duration	Adverse Reaction?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**DELETE**

**ADD ITEM**

**Visit Summary**

Abnormal Findings	Recommendations and Action Plans
<input type="text"/>	<input type="text"/>

**DELETE**


**ADD ITEM**

**Reviewer's Notes About This Medical Office Visit**

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# Medical Transport

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Medical Transport **UNDO** **SAVE**

record: 1

new-last-name, new-first-name

Date of Transport

Month

Day


Year

Gestational Age- Weeks

Gestational Age- Days

Days Postpartum

Reason for Transport

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Reason for Transport

Maternal Conditions (Describe)

Who Managed the Transport?

Specify Other

Transport Vehicle

Specify Other

Timing of Transport

Call Received

Depart for Patient Origin



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### 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

Specify Other

If Hospital Chosen Enter Trauma Level of Care

Specify Other Trauma Level of Care

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Specify Other Trauma Level of Care

If Hospital Chosen Enter Maternal Level of Care

Specify Other Maternal Level of Care

Comments

Procedures Before Transport (Describe)

Procedures During Transport (Describe)

Transport Vital Signs

Date and Time

GA- Weeks

GA- Days

Systolic BP

Diastolic BP

Oxygen Saturation

Blood Sugar

Transport Vital Signs

Date and Time	GA- Weeks	GA- Days	Systolic BP	Diastolic BP	Oxygen Saturation	Blood Sugar
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DELETE

ADD ITEM

Mental Status of Patient During Transport (Describe)

Documented Pertinent Oral Statements Made by Patient or Others on Scene

Destination Information

Place of Destination

Trauma Level of Care

Specify Other Trauma Level of Care

Maternal Level of Care

Trauma Level of Care

Specify Other Trauma Level of Care

Maternal Level of Care

Specify Other Maternal Level of Care

Comments


Reviewer's Notes About Medical Transport

Transport was notified at \_\_\_\_\_ (time)  
for \_\_\_\_\_ (reason). Upon arrival at  
\_\_\_\_\_ (place of origin) she was found to  
be \_\_\_\_\_ (weeks gestation OR days  
postpartum) with

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# Social and Environmental Profile

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### Mental Health Profile **UNDO** **SAVE**

new-last-name, new-first-name

Were There Documented Preexisting Mental Health Conditions?\*

Condition	Duration of Condition	Treatment(s)	Duration of Treatment	Treatment Changed During Pregnancy?	Dosage Changed During Pregnancy?	If Yes, Mental Health Provider Consultation During this Pregnancy?	Did Patient Adhere to Treatment?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**DELETE** **ADD ITEM**

Were There Documented Screenings and Referrals for Mental Health Conditions?


Date of Screening	GA- Weeks	GA- Days	Days Postpartum	Screening Tool	Referral for Treatment
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**DELETE** **ADD ITEM**

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)\*

<https://www.cdc.gov>

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Was the Decedent TREATED for Any of the Following Mental Health Conditions PRIOR TO 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 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

<https://www.cdc.gov>

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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

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# Mental Health Profile

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### Mental Health Profile **UNDO** **SAVE**

new-last-name, new-first-name

Were There Documented Preexisting Mental Health Conditions?\*

Documented Preexisting Mental Health Conditions

Condition	Duration of Condition	Treatment(s)	Duration of Treatment	Treatment Changed During Pregnancy?	Dosage Changed During Pregnancy?	If Yes, Mental Health Provider Consultation During this Pregnancy?	Did Patient Adhere to Treatment?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**DELETE** **ADD ITEM**

Were There Documented Screenings and Referrals for Mental Health Conditions?

Date of Screening	GA- Weeks	GA- Days	Days Postpartum	Screening Tool	Referral for Treatment
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**DELETE** **ADD ITEM**

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

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Was the Decedent TREATED for Any of the Following Mental Health Conditions PRIOR TO 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 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

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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

**UNDO**

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# Informant Interviews

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Informant Interviews **UNDO** **SAVE**

record: 1

new-last-name, new-first-name

Date of Interview

Month

Day

Year


Interview Type\*

Specify Other Type

Age Group

Relationship To Deceased

Other Relationship

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Other Relationship

Ethnicity

Race

Black  
White  
American Indian / Alaska Native  
Hawaiian / Pacific Islander  
Asian  
...

Interview Narrative

Reviewer's Notes About the Informant Interview

**UNDO** **SAVE**