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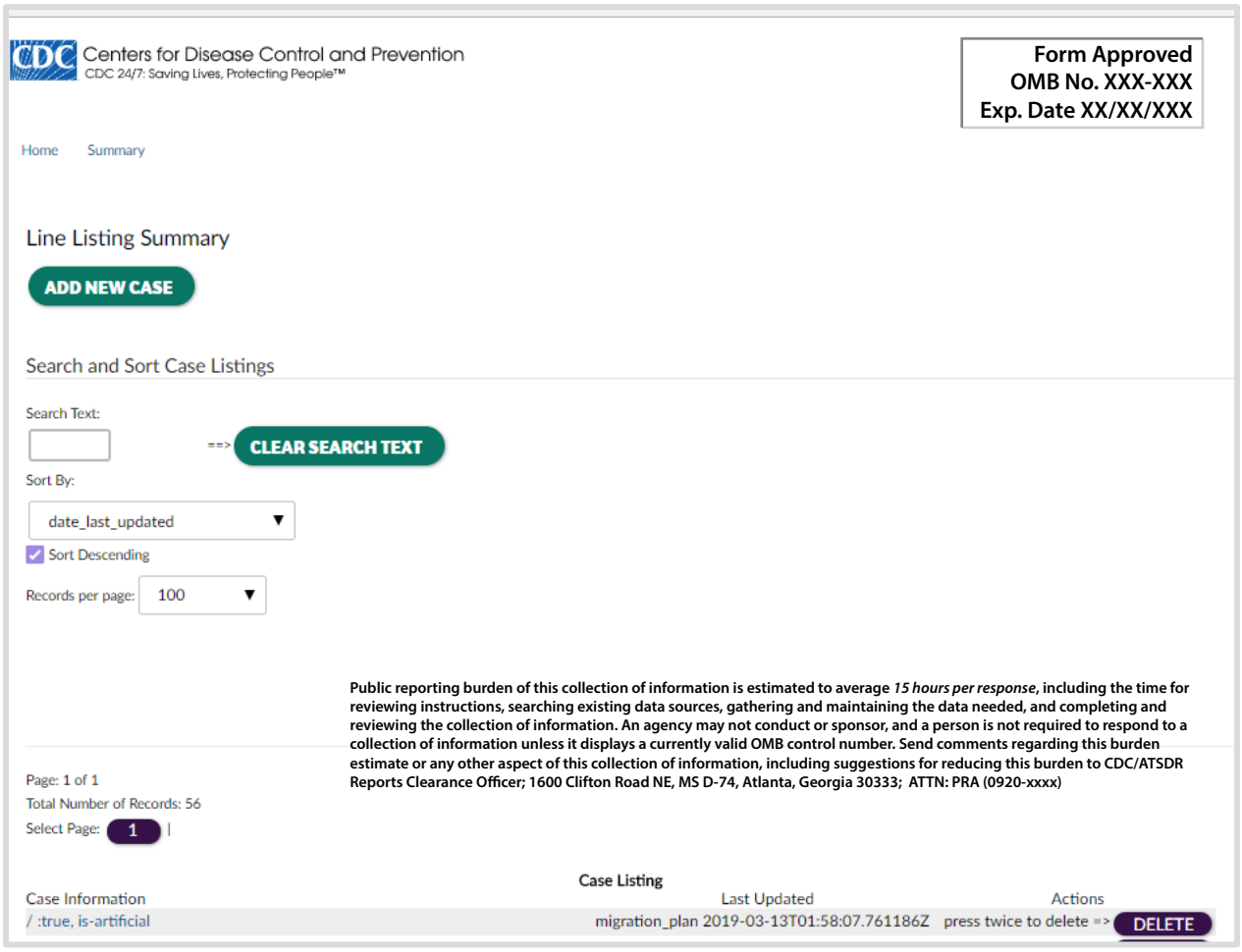
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Form Approved
OMB No. XXX-XXX
Exp. Date XX/XX/XXX
Home
Summary
Line Listing Summary
ADD NEW CASE
Search and Sort Case Listings
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==>
CLEAR SEARCH TEXT
Sort By:
date_last_updated
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Records per page:
100
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
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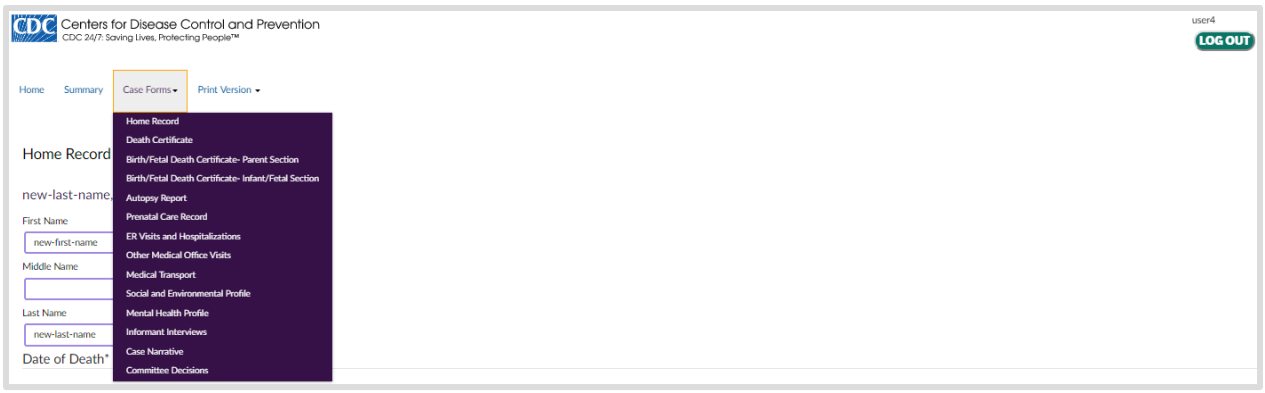
Case Information
Last Updated
Actions
/ :true, is-artificial
migration_plan 2019-03-13T01:58:07.761186Z
press twice to delete =>
DELETE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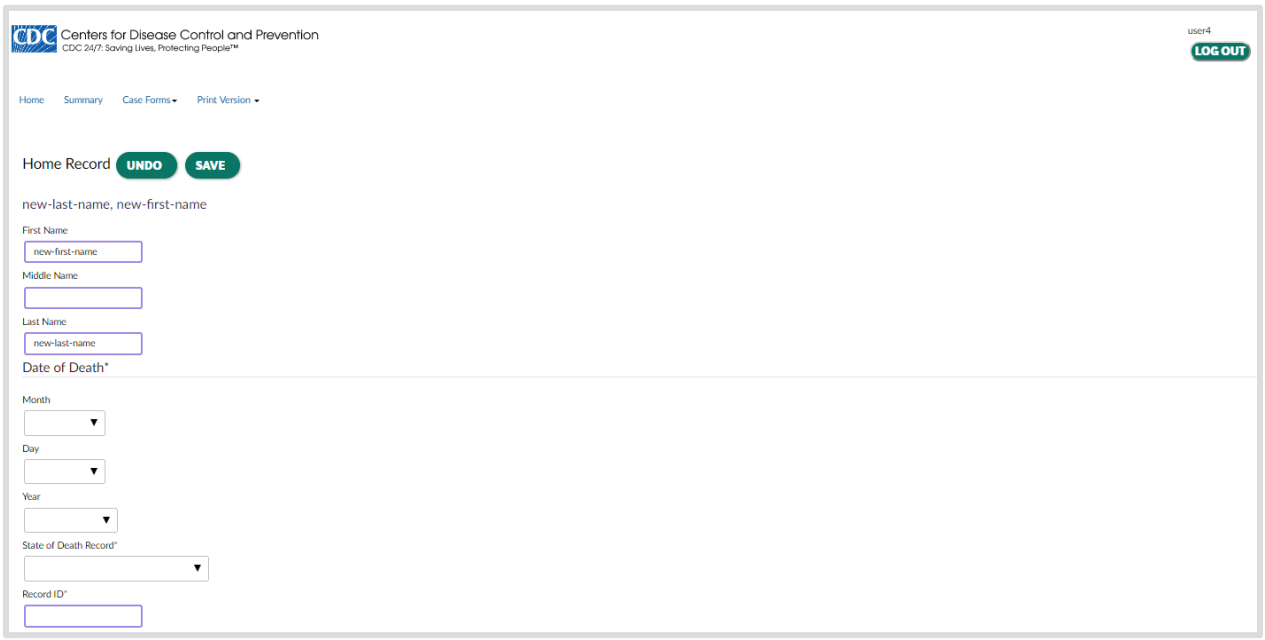
Death Certificate
Birth/Fetal Death Certificate- Parent Section
Birth/Fetal Death Certificate- Infant/Fetal Section
Autopsy Report
Prenatal Care Record
ER Visits and Hospitalizations
Other Medical Office Visits
Medical Transport
Social and Environmental Profile
Mental Health Profile
Informant Interviews
Case Narrative
Committee Decisions
new-last-name,
First Name
new-first-name
Middle Name
Last Name
new-last-name
Date of Death*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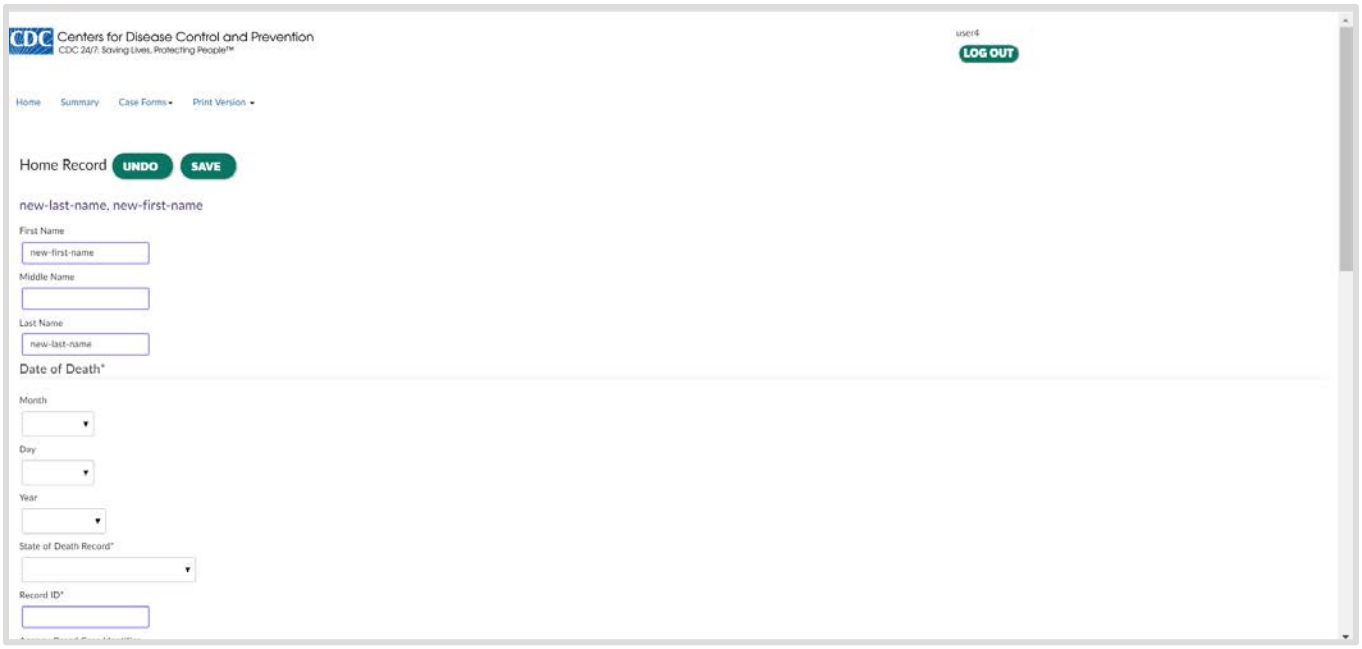
UNDO
SAVE
new-last-name, new-first-name
First Name
new-first-name
Middle Name
Last Name
new-last-name
Date of Death*
Month
Day
Year
State of Death Record*
Record ID*

Home Record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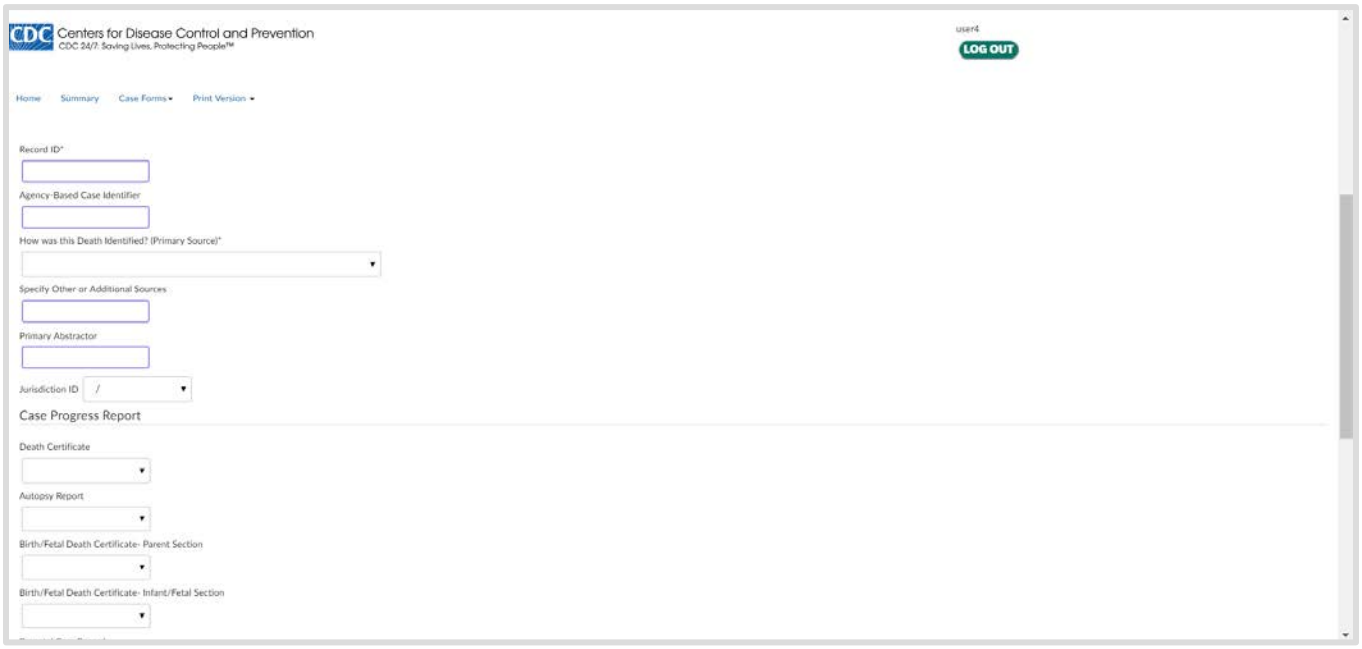
new-last-name, new-first-name
First Name
new-first-name
Middle Name
Last Name
new-last-name
Date of Death*
Month
Day
Year
State of Death Record*
Record ID*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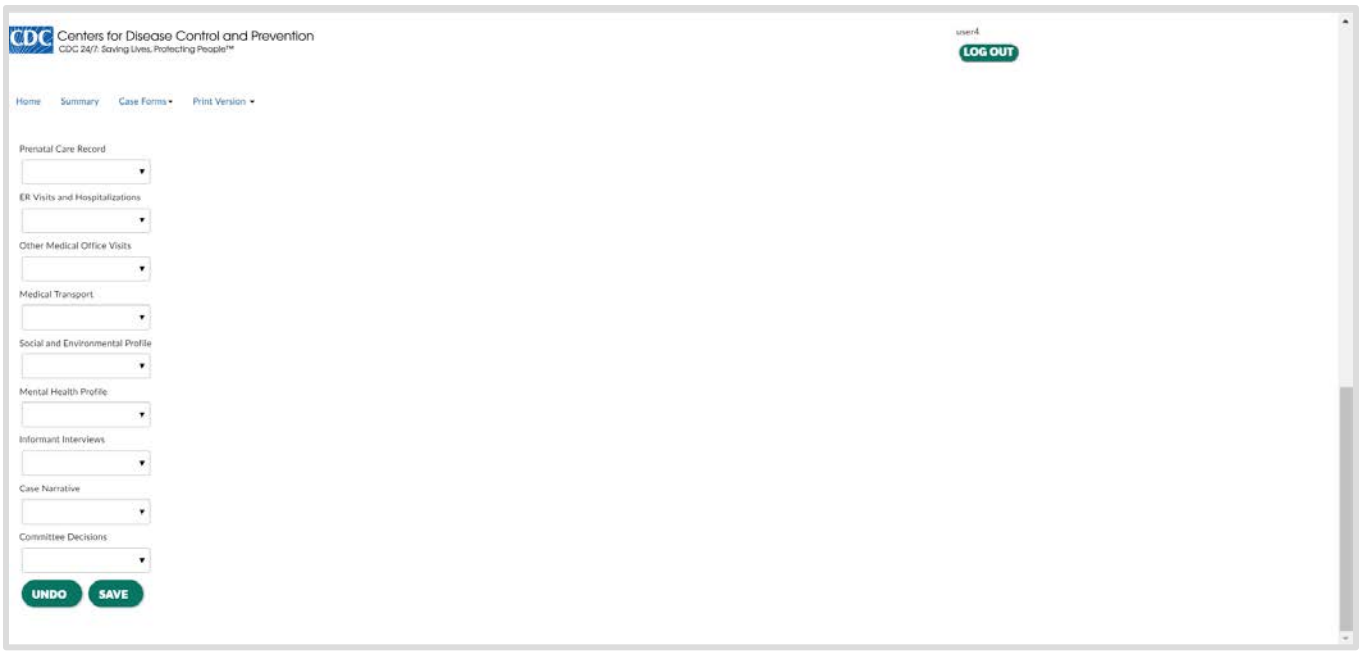
Record ID*
Agency-Based Case Identifier
How was this Death Identified? (Primary Source)*
Specify Other or Additional Sources
Primary Abstractor
Jurisdiction ID
/
Case Progress Report
Death Certificate
Autopsy Report
Birth/Fetal Death Certificate- Parent Section
Birth/Fetal Death Certificate- Infant/Fetal Section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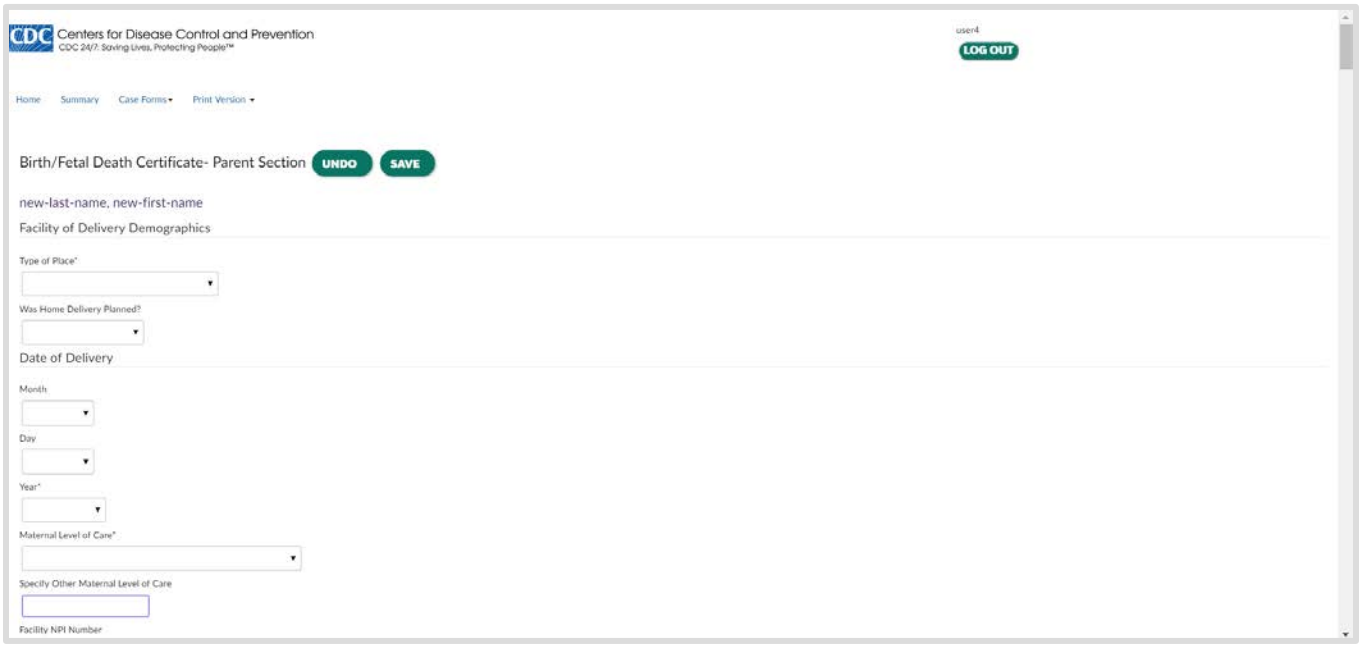
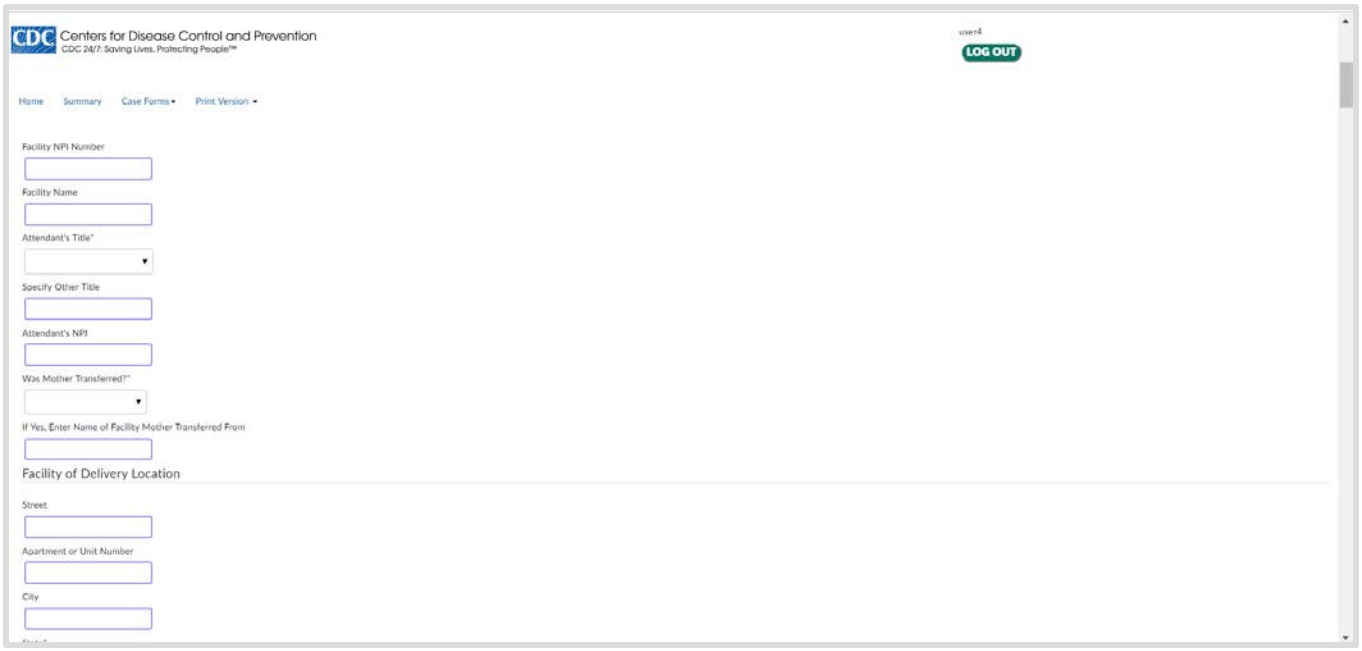
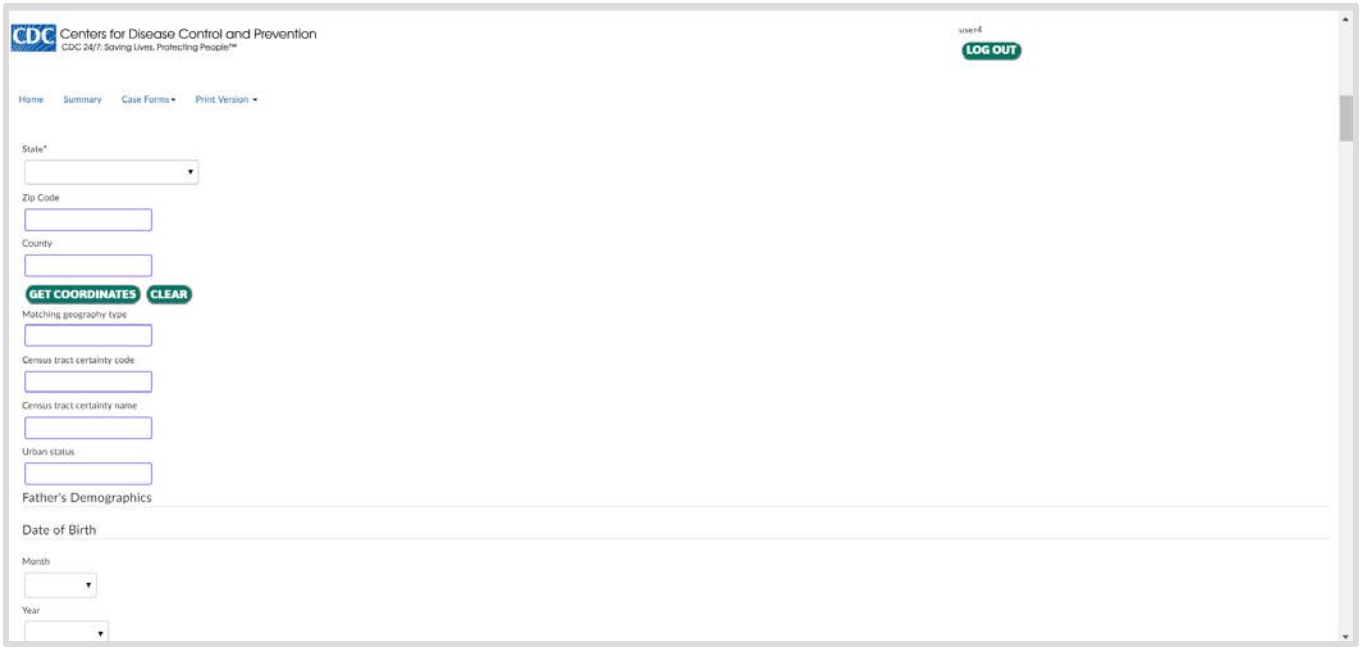
SAVE

Birth/Fetal Death Certificate – Parent Section



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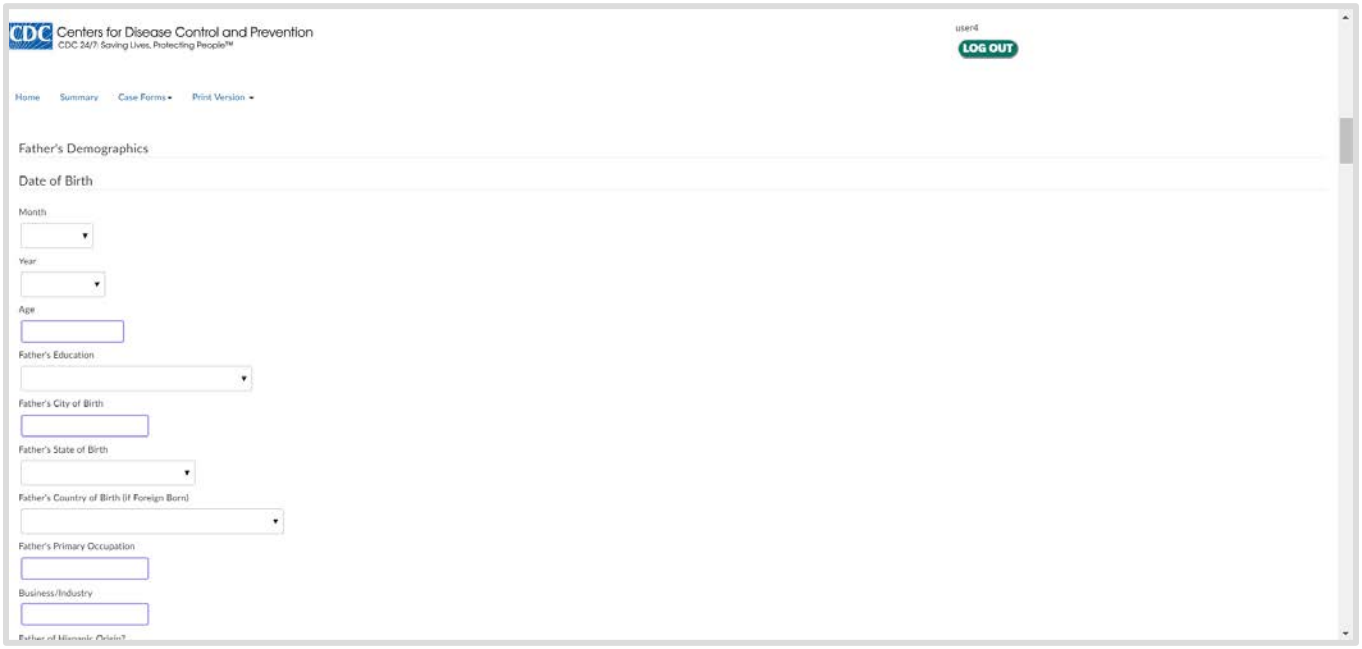
State*
Zip Code
County
GET COORDINATES
CLEAR
Matching geography type
Census tract certainty code
Census tract certainty name
Urban status
Father's Demographics
Date of Birth
Month
Year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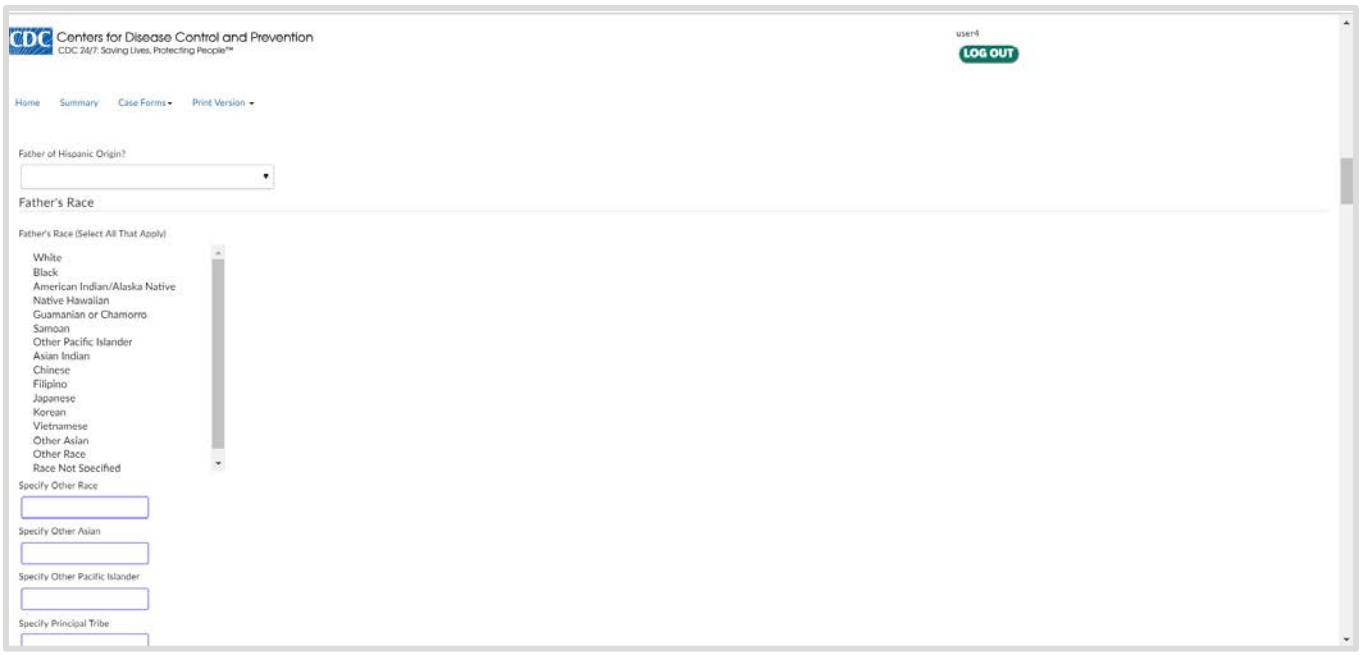
Father's Demographics
Date of Birth
Month
Year
Age
Father's Education
Father's City of Birth
Father's State of Birth
Father's Country of Birth (if Foreign Born)
Father's Primary Occupation
Business/Industry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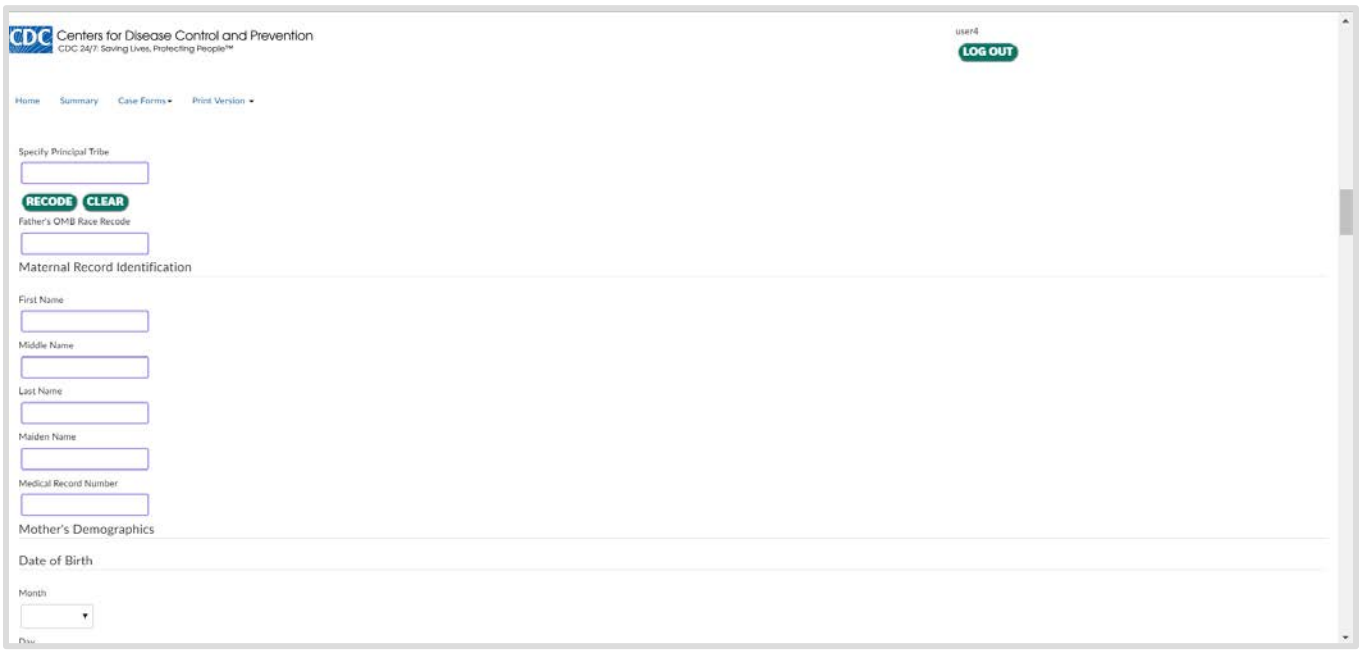
Father of Hispanic Origin?
Father's Race
Father's Race (Select All That Apply)
White
Black
American Indian/Alaska Native
Native Hawaiian
Guamanian or Chamorro
Samoan
Other Pacific Islander
Asian Indian
Chinese
Filipino
Japanese
Korean
Vietnamese
Other Asian
Other Race
Race Not Specified
Specify Other Race
Specify Other Asian
Specify Other Pacific Islander
Specify Principal Tribe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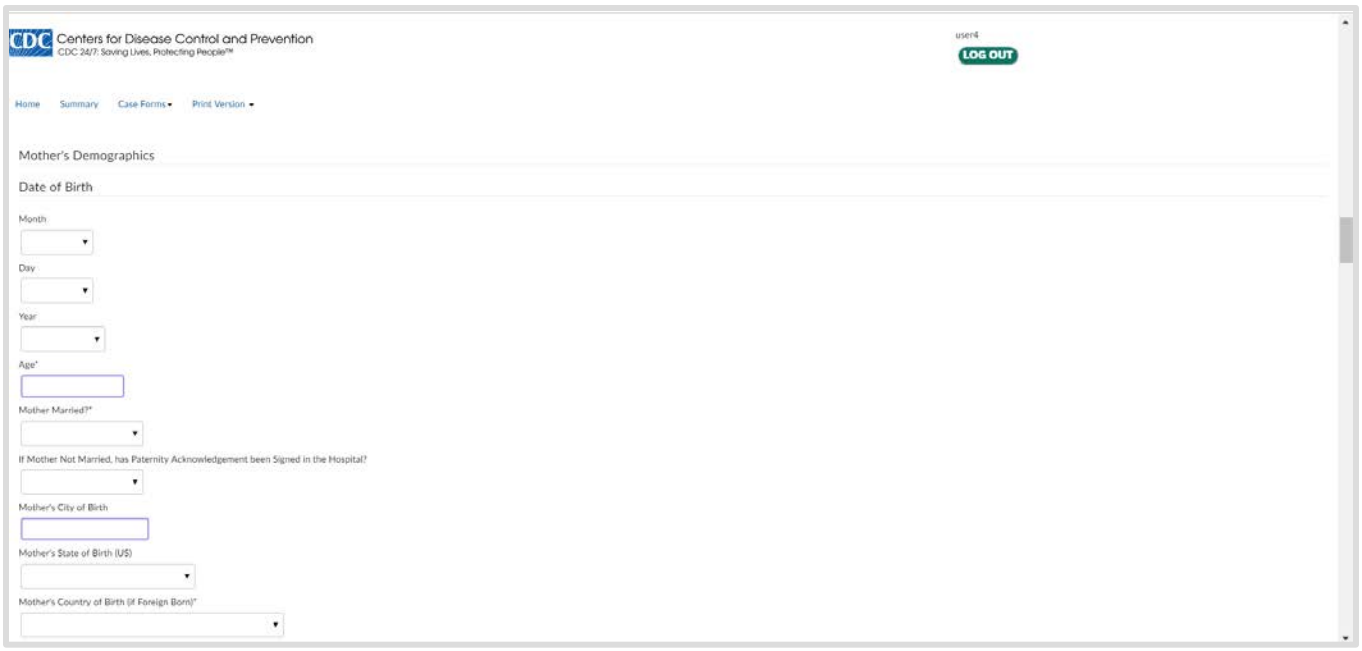
Specify Principal Tribe
RECODE
CLEAR
Father's OMB Race Recode
Maternal Record Identification
First Name
Middle Name
Last Name
Maiden Name
Medical Record Number
Mother's Demographics
Date of Birth
Month


Centers for Disease Control and Prevention
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user4
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Summary
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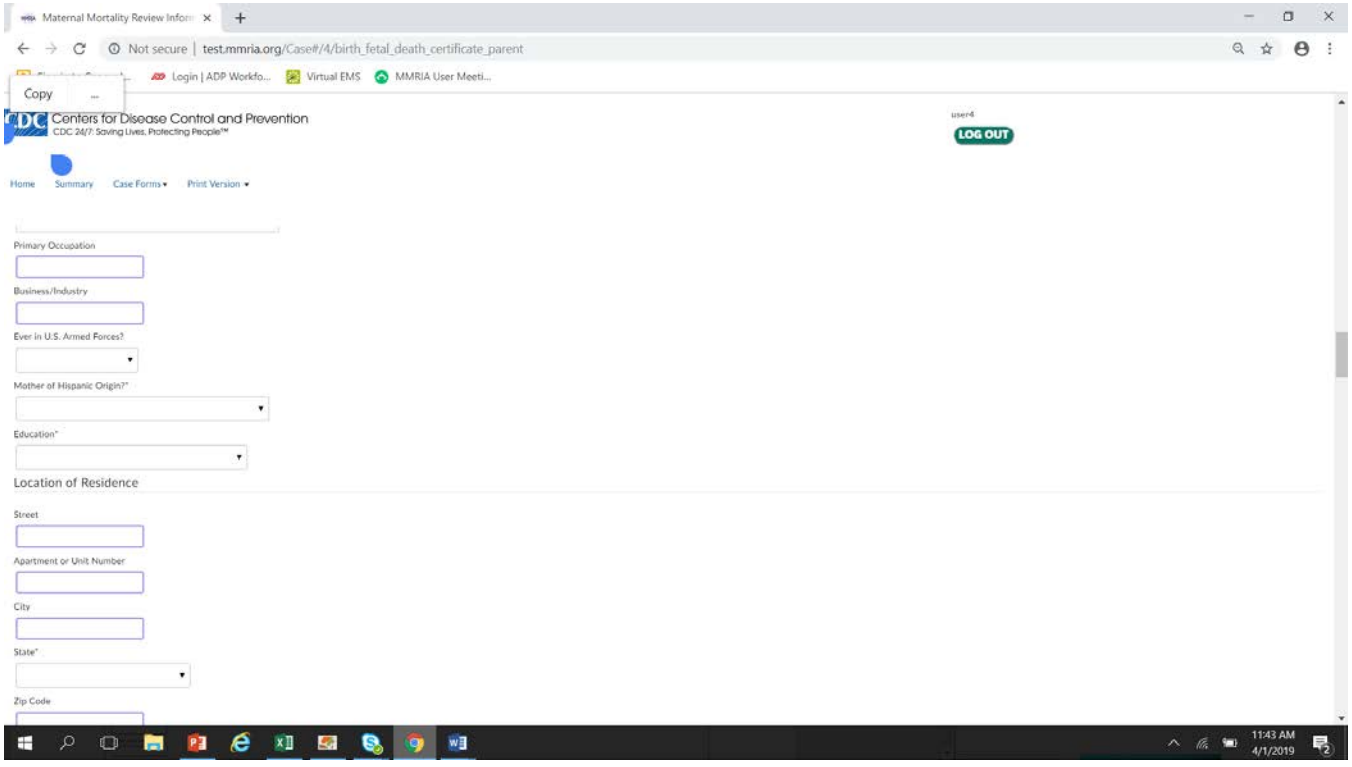
Print Version
Mother's Demographics
Date of Birth
Month
Day
Year
Age*
Mother Married?*
If Mother Not Married, has Paternity Acknowledgement been Signed in the Hospital?
Mother's City of Birth
Mother's State of Birth (US)
Mother's Country of Birth (if Foreign Born)*


Maternal Mortality Review Inform
Not secure | test.mmria.org/Case#/4/birth_fetal_death_certificate_parent
Login | ADP Workfo...
Virtual EMS
MMRIA User Meeti...
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Summary
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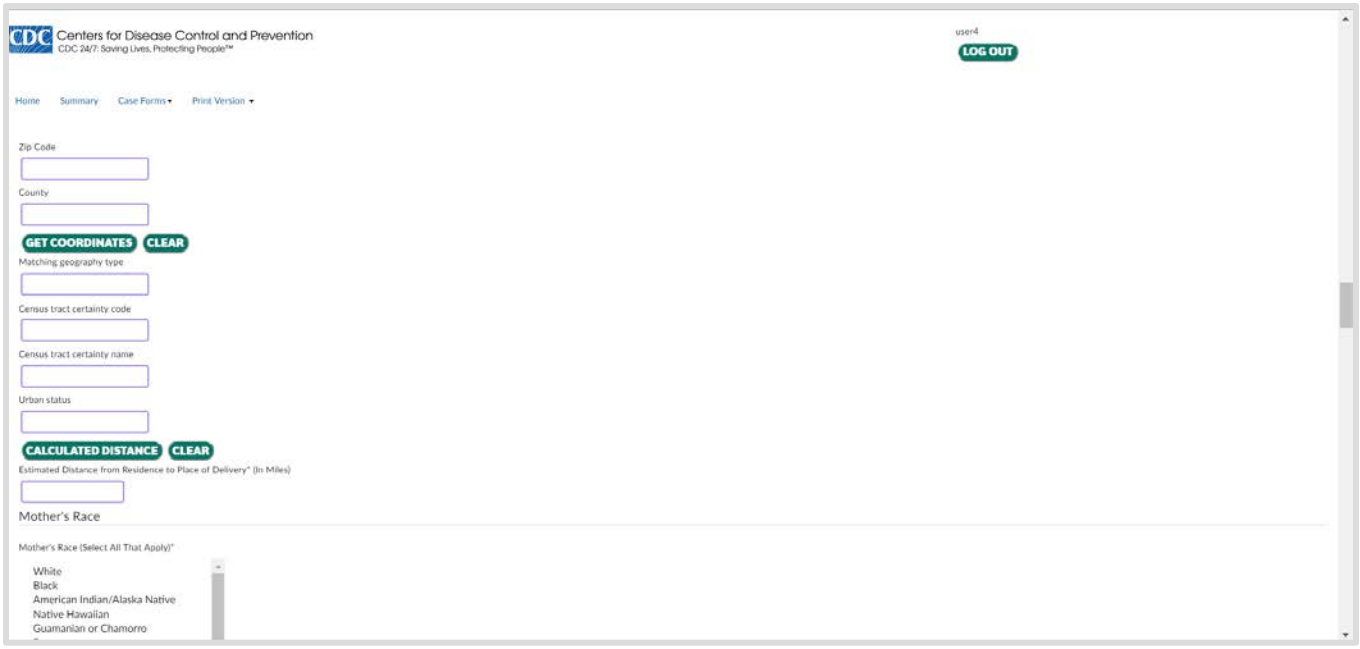
Primary Occupation
Business/Industry
Ever in U.S. Armed Forces?
Mother of Hispanic Origin?*
Education*
Location of Residence
Street
Apartment or Unit Number
City
State*
Zip Code
11:43 AM
4/1/2019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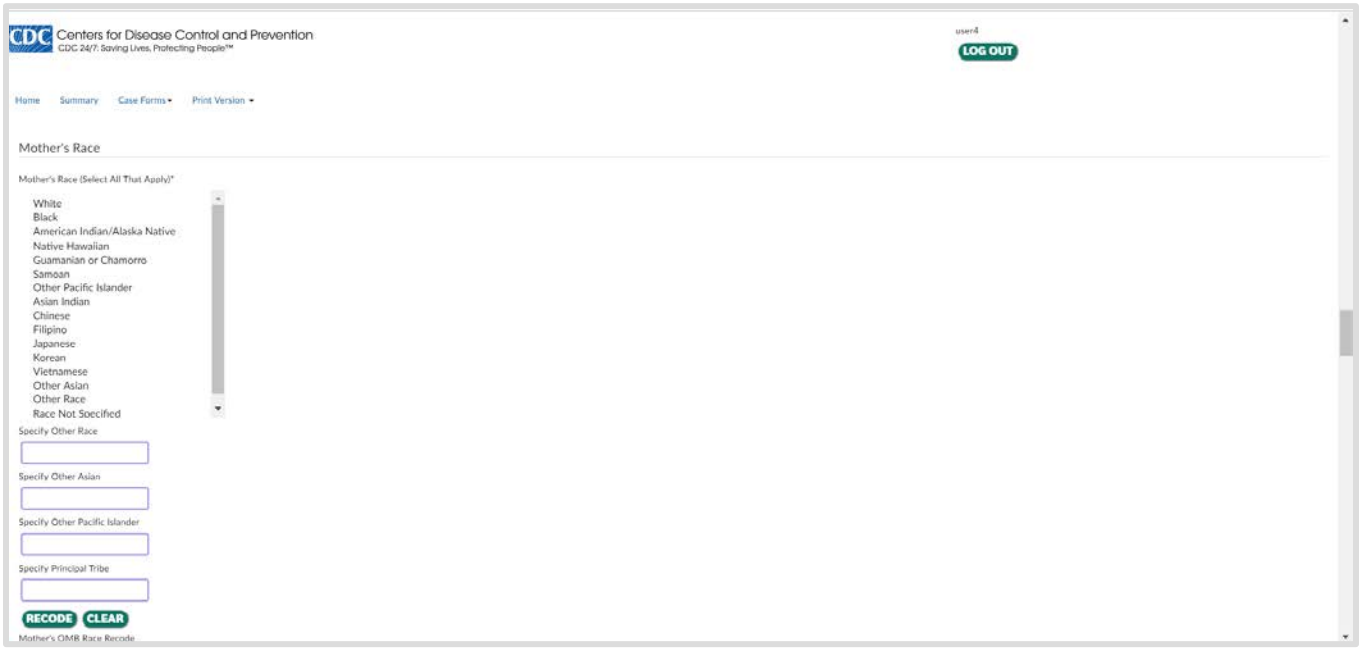
Zip Code
County
GET COORDINATES
CLEAR
Matching geography type
Census tract certainty code
Census tract certainty name
Urban status
CALCULATED DISTANCE
CLEAR
Estimated Distance from Residence to Place of Delivery* (In Miles)
Mother's Race
Mother's Race (Select All That Apply)*
White
Black
American Indian/Alaska Native
Native Hawaiian
Guamanian or Chamorro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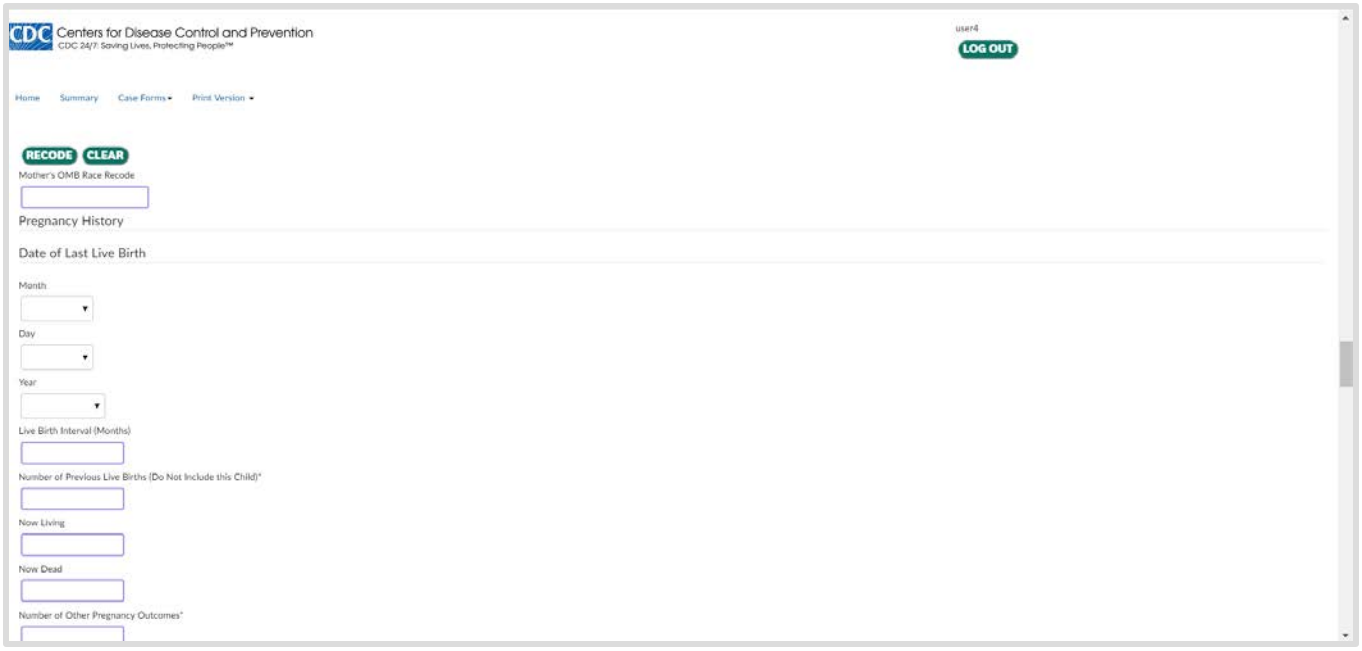
Mother's Race
Mother's Race (Select All That Apply)*
White
Black
American Indian/Alaska Native
Native Hawaiian
Guamanian or Chamorro
Samoan
Other Pacific Islander
Asian Indian
Chinese
Filipino
Japanese
Korean
Vietnamese
Other Asian
Other Race
Race Not Specified
Specify Other Race
Specify Other Asian
Specify Other Pacific Islander
Specify Principal Tribe
RECODE
CLEAR
Mother's OMB Race Recode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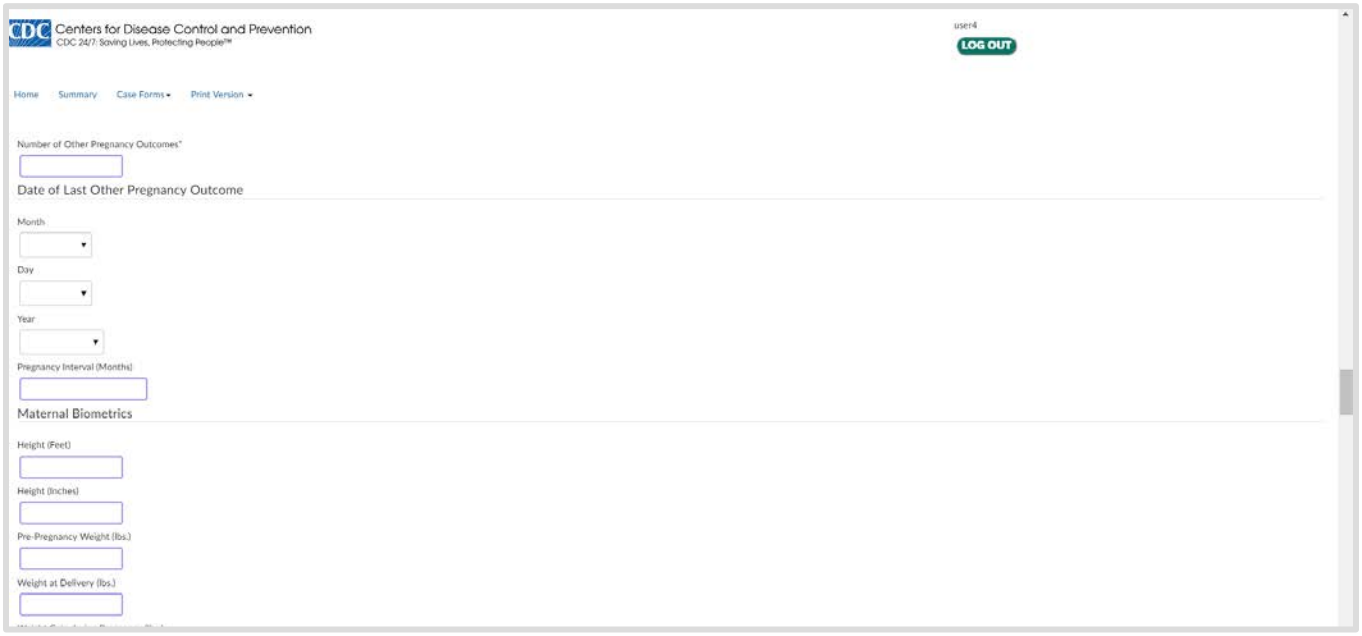
RECODE
CLEAR
Mother's OMB Race Recode
Pregnancy History
Date of Last Live Birth
Month
Day
Year
Live Birth Interval (Months)
Number of Previous Live Births (Do Not Include this Child)*
Now Living
Now Dead
Number of Other Pregnancy Outcomes*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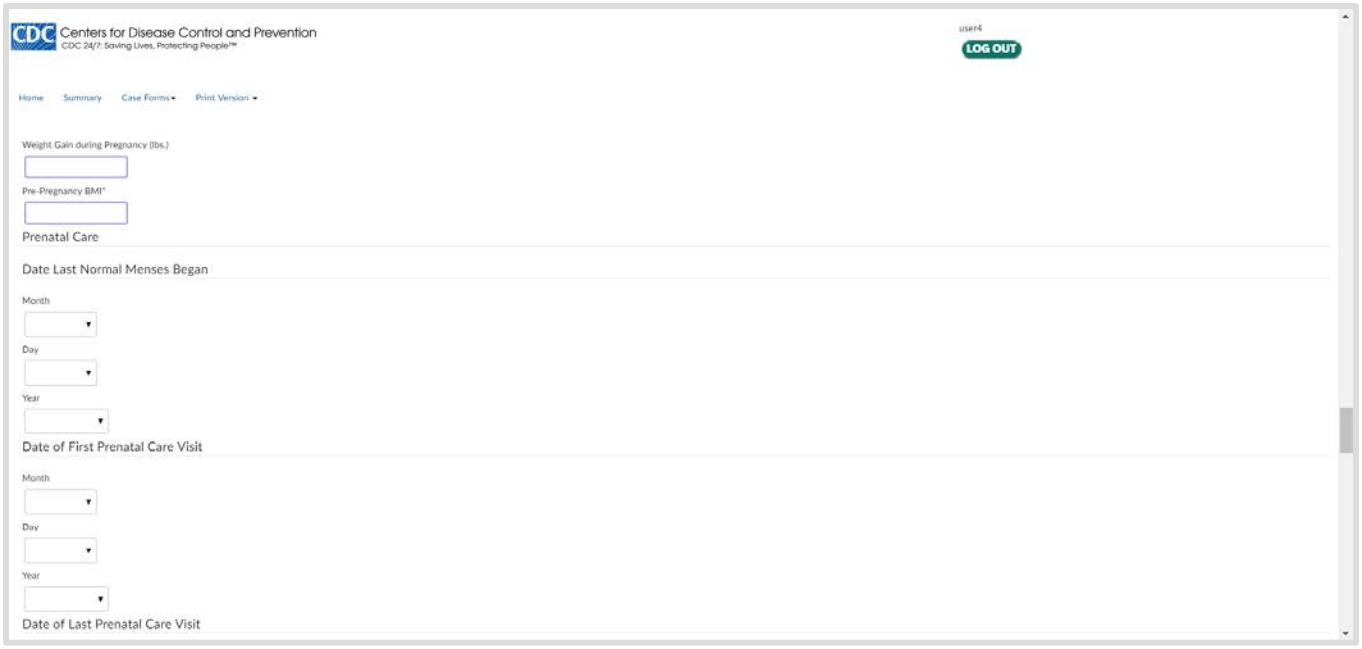
Number of Other Pregnancy Outcomes*
Date of Last Other Pregnancy Outcome
Month
Day
Year
Pregnancy Interval (Months)
Maternal Biometrics
Height (Feet)
Height (Inches)
Pre-Pregnancy Weight (lbs.)
Weight at Delivery (lbs.)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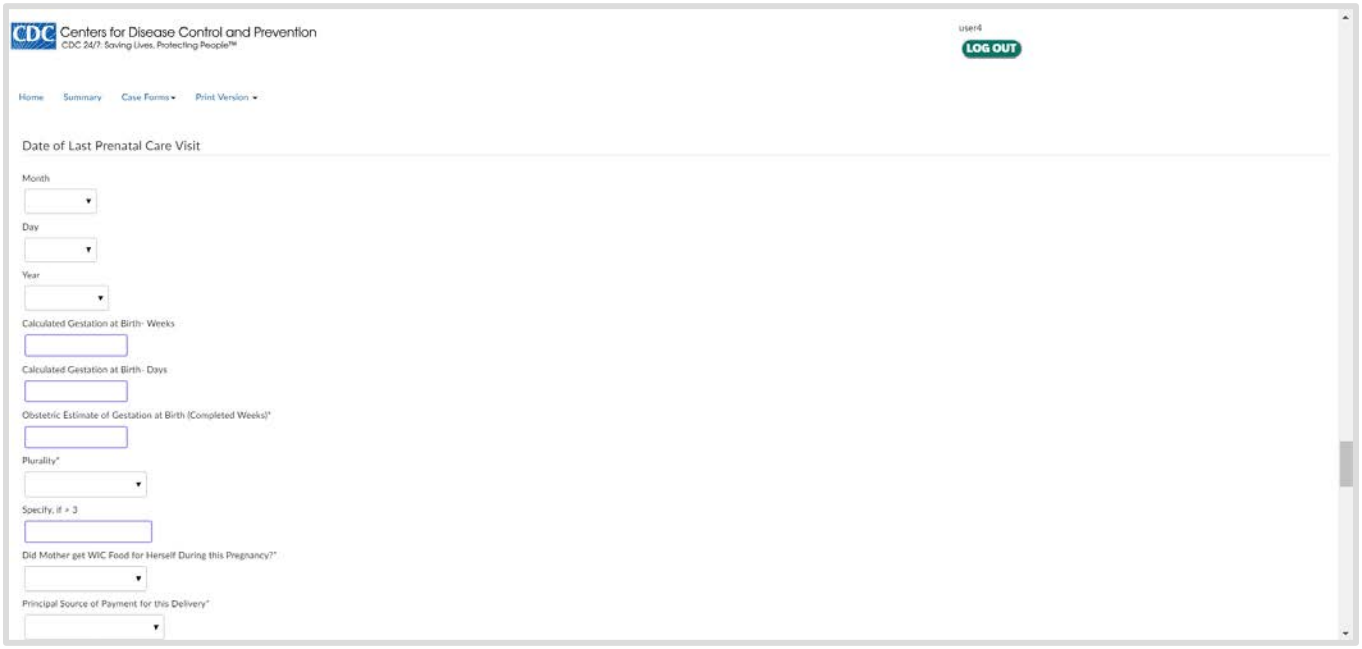
Weight Gain during Pregnancy (lbs.)
Pre-Pregnancy BMI*
Prenatal Care
Date Last Normal Menses Began
Month
Day
Year
Date of First Prenatal Care Visit
Month
Day
Year
Date of Last Prenatal Care Visit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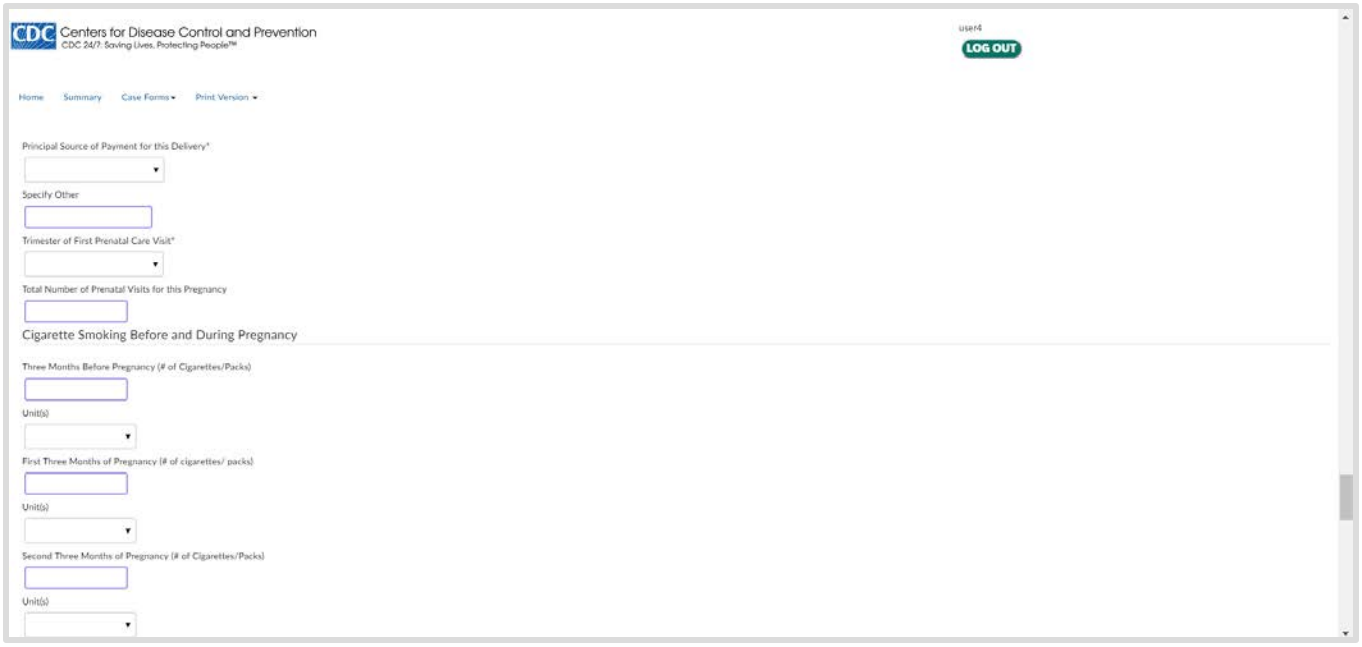
Date of Last Prenatal Care Visit
Month
Day
Year
Calculated Gestation at Birth- Weeks
Calculated Gestation at Birth- Days
Obstetric Estimate of Gestation at Birth (Completed Weeks)*
Plurality*
Specify, if > 3
Did Mother get WIC Food for Herself During this Pregnancy?*
Principal Source of Payment for this Delivery*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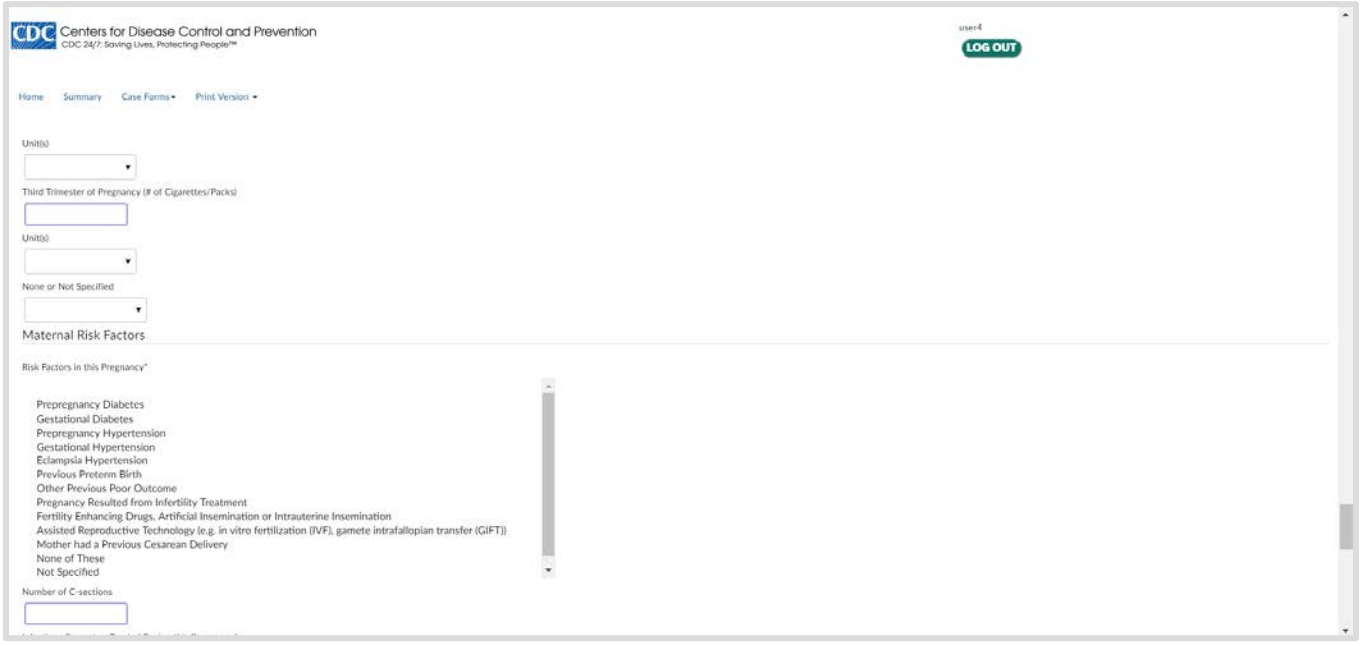
Principal Source of Payment for this Delivery*
Specify Other
Trimester of First Prenatal Care Visit*
Total Number of Prenatal Visits for this Pregnancy
Cigarette Smoking Before and During Pregnancy
Three Months Before Pregnancy (# of Cigarettes/Packs)
Unit(s)
First Three Months of Pregnancy (# of cigarettes/ packs)
Unit(s)
Second Three Months of Pregnancy (# of Cigarettes/Packs)
Unit(s)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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


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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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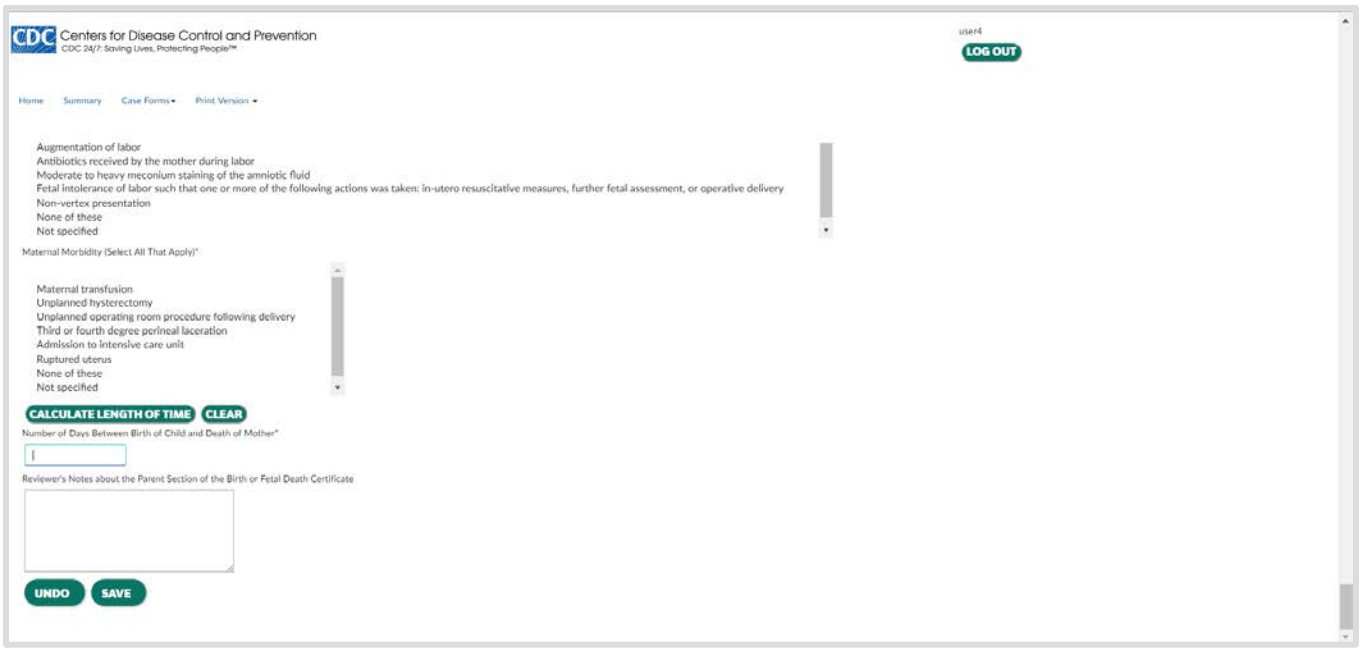
Characteristics of Labor and Delivery (Select All That Apply)*
Induction of labor
Steroids (glucocorticoids) for fetal lung maturation received by mother prior to delivery
Clinical chorioamnionitis diagnosed during labor or maternal temperature >= 38 degrees C (100.4 degrees F)
Epidural or spinal anesthesia 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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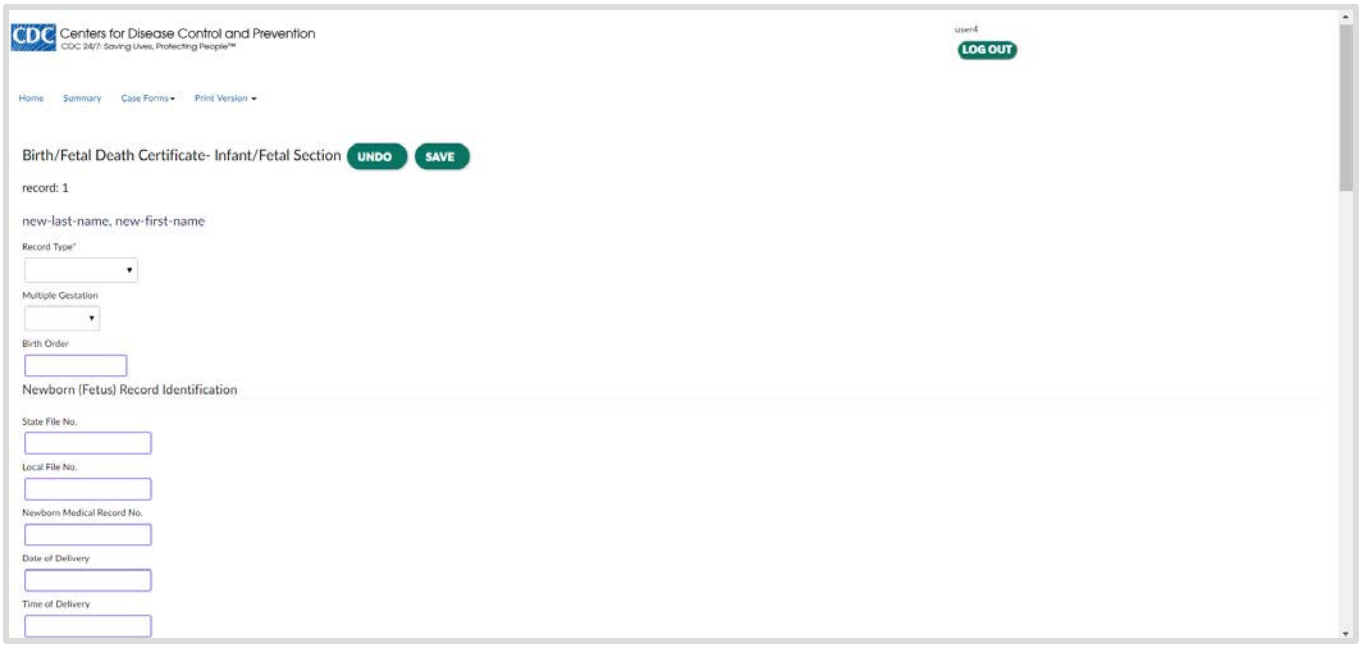
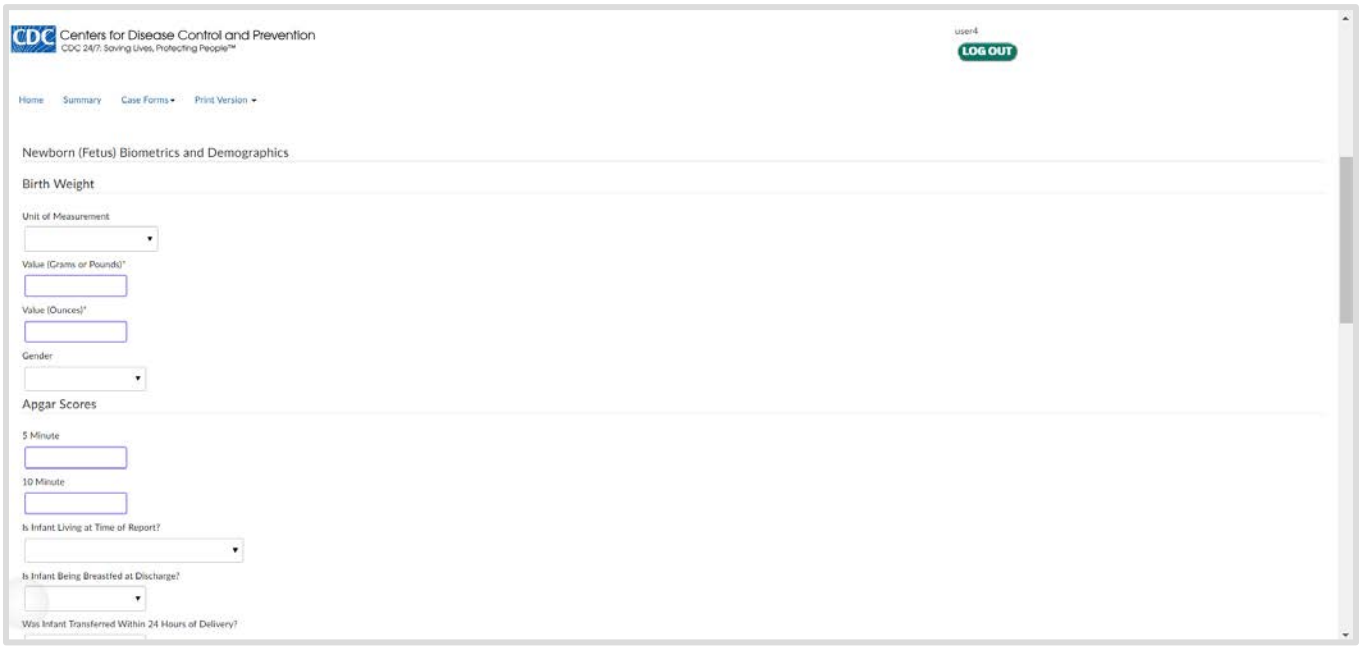
Augmentation of labor
Antibiotics received by the mother during labor
Moderate to heavy meconium staining of the amniotic fluid
Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
Non-vertex 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
UNDO
SAVE

Birth/Fetal Death Certificate- Infant/Fetal Section



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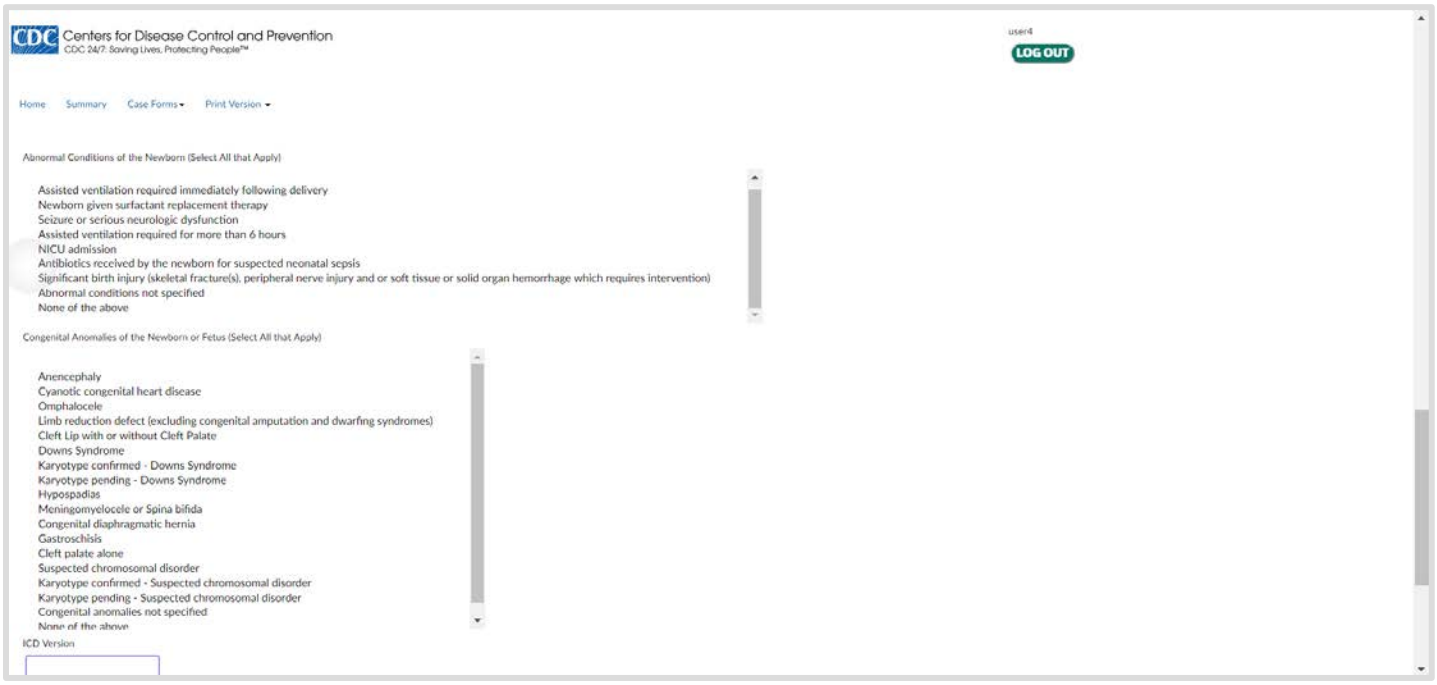
Was Infant Transferred Within 24 Hours of Delivery?
Specify Facility, City and State
Method of Delivery
A. Was Delivery With Forceps Attempted but Unsuccessful?
B. Was Delivery With Vacuum Extraction Attempted but Unsuccessful?
C. Fetal Presentation at Birth
Other Presentation
D. Final Route and Method 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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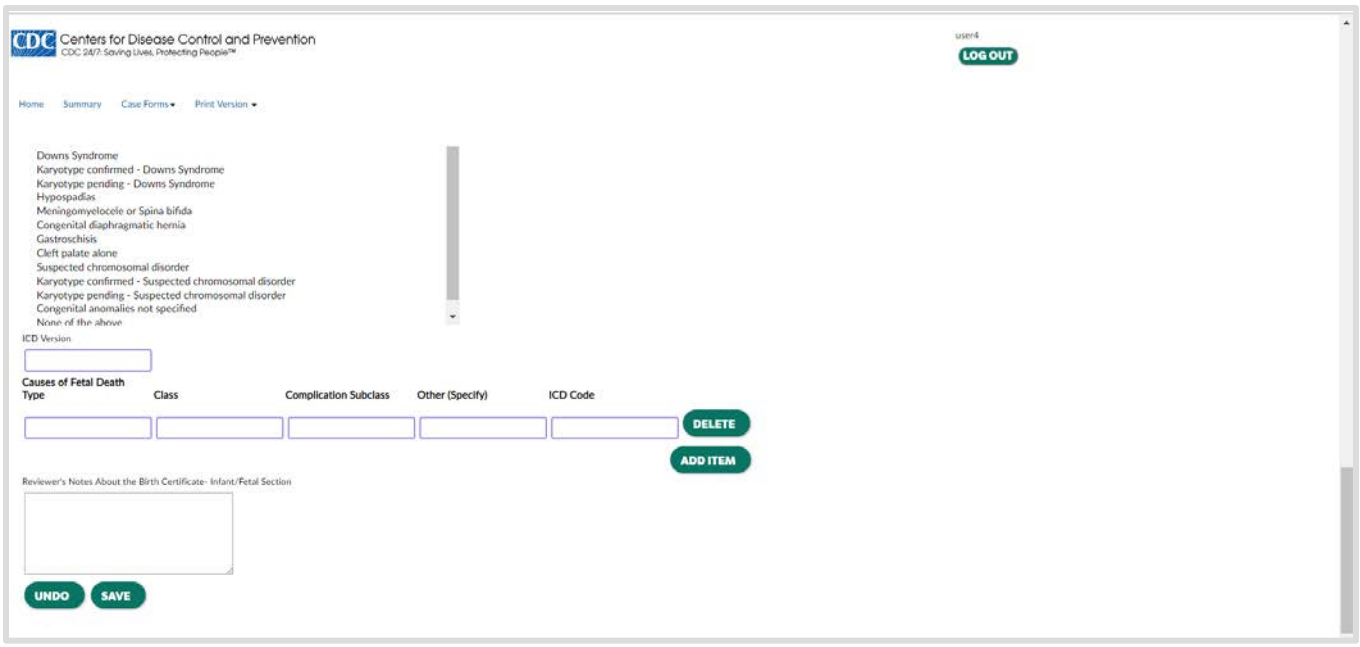
Abnormal Conditions of the Newborn (Select All that Apply)
Assisted ventilation required immediately following delivery
Newborn given surfactant replacement therapy
Seizure or serious neurologic dysfunction
Assisted ventilation required for more than 6 hours
NICU admission
Antibiotics received by the 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
Meningomyelocele 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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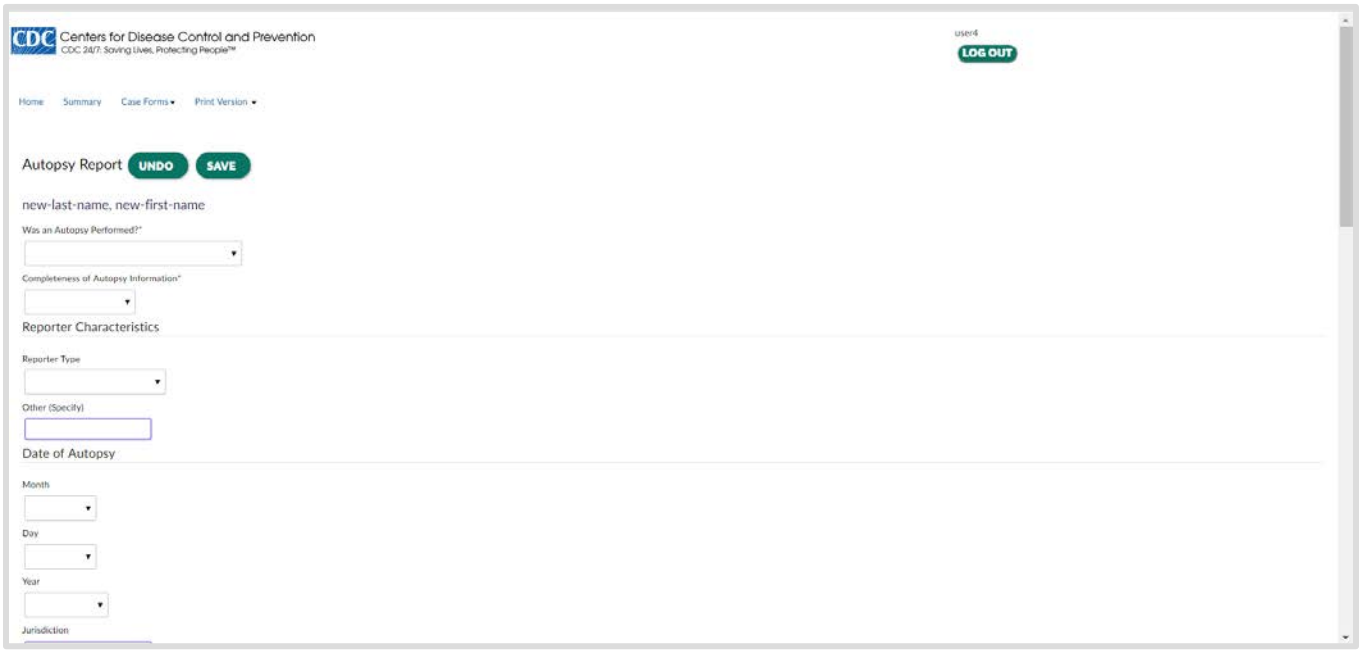
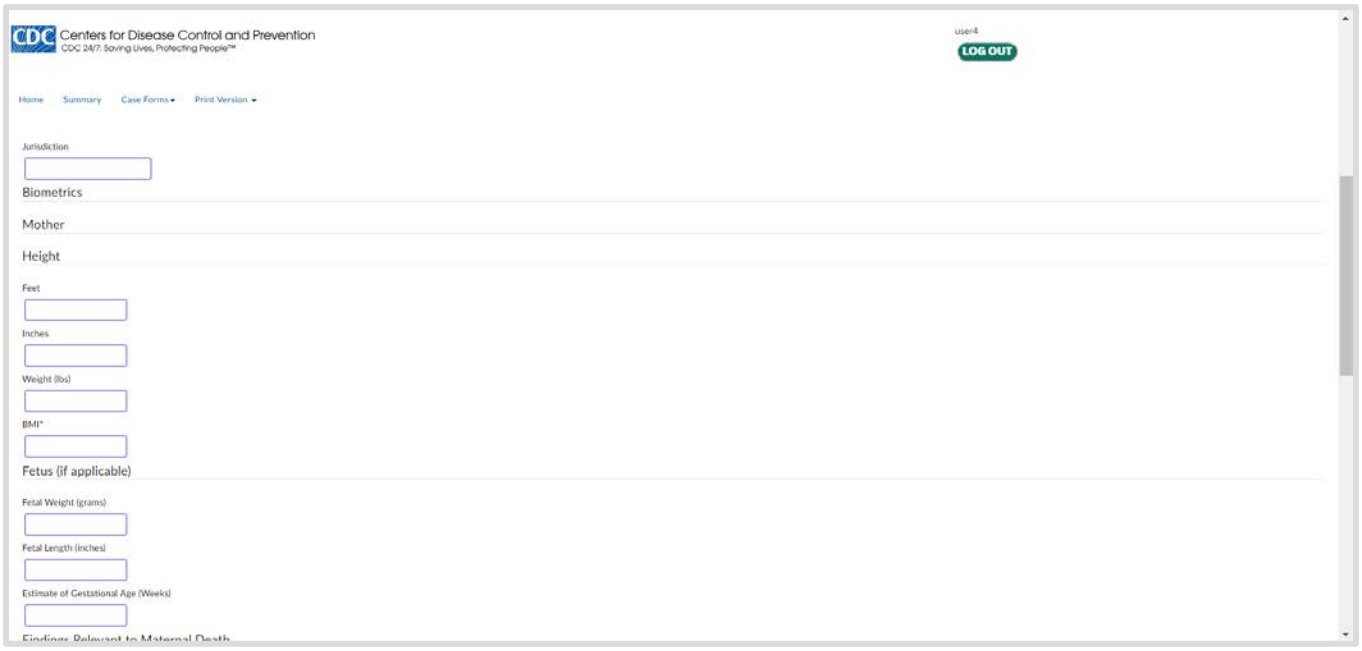
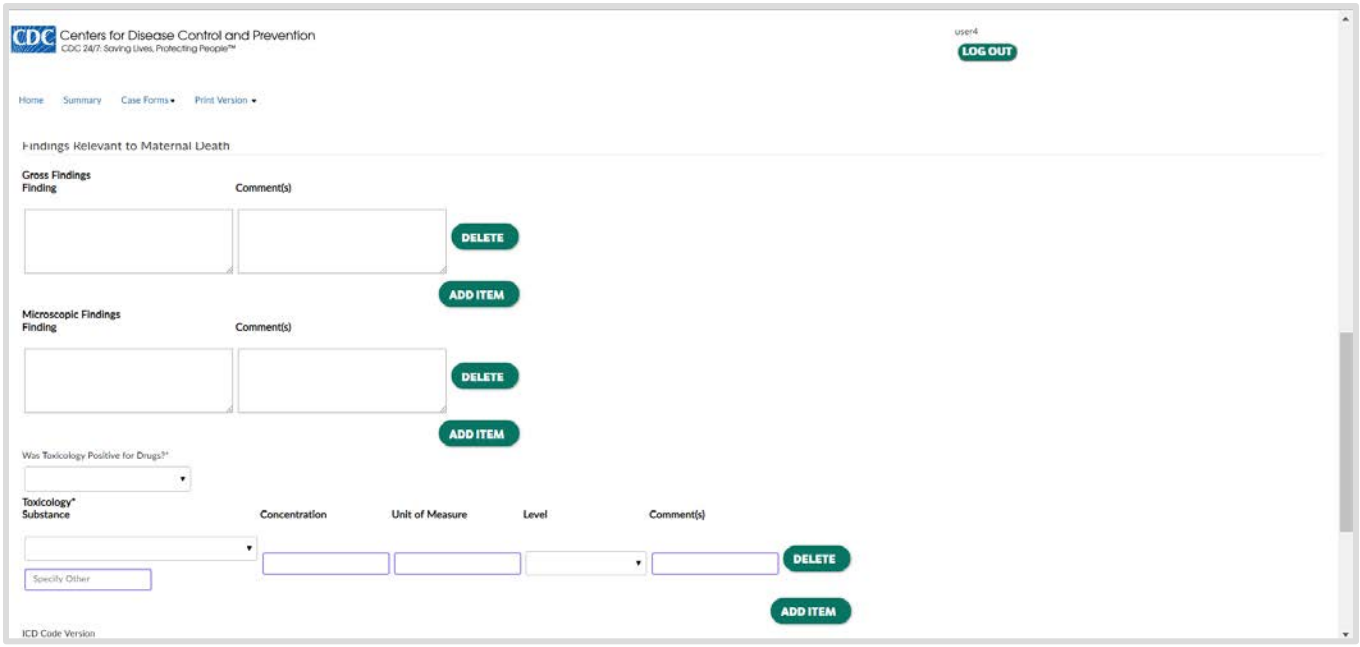
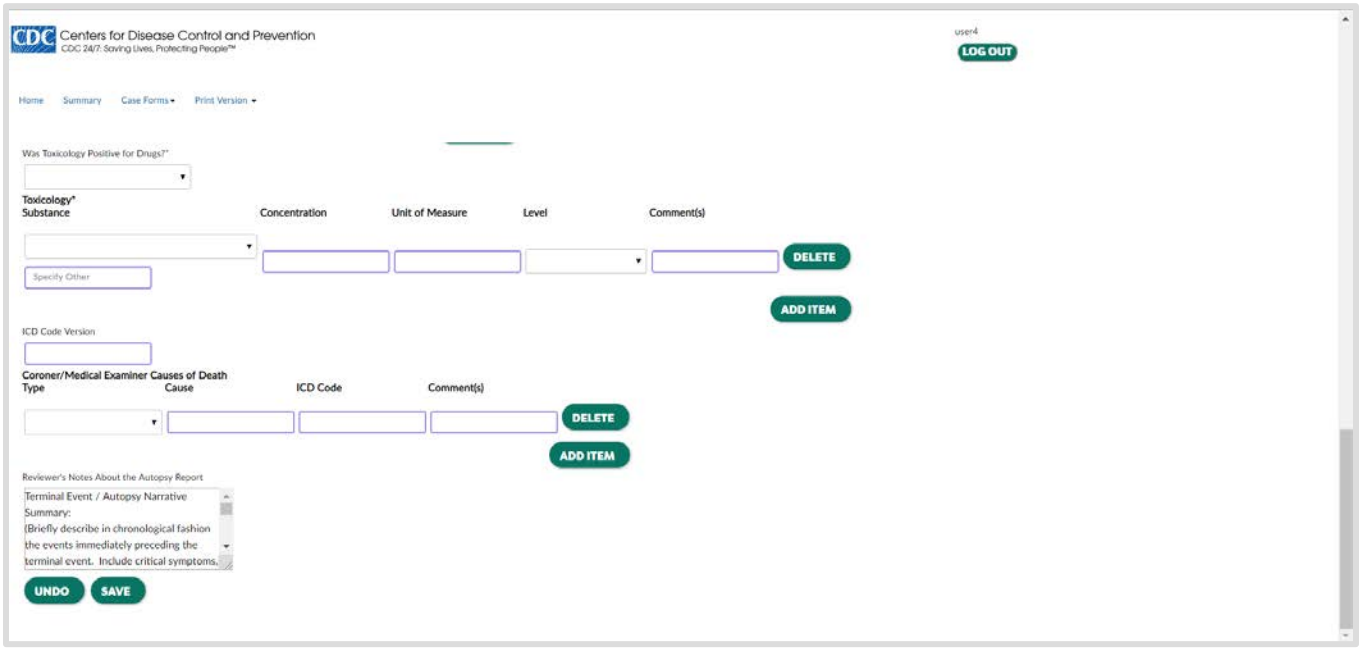
Downs Syndrome
Karyotype confirmed - Downs Syndrome
Karyotype pending - Downs Syndrome
Hypospadias
Meningomyelocele or Spina bifida
Congenital diaphragmatic hernia
Gastroschisis
Cleft palate alone
Suspected chromosomal disorder
Karyotype confirmed - Suspected chromosomal disorder
Karyotype pending - 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
DELETE
ADD ITEM
Reviewer's Notes About the Birth Certificate- Infant/Fetal Section
UNDO
SAVE

Autopsy Report

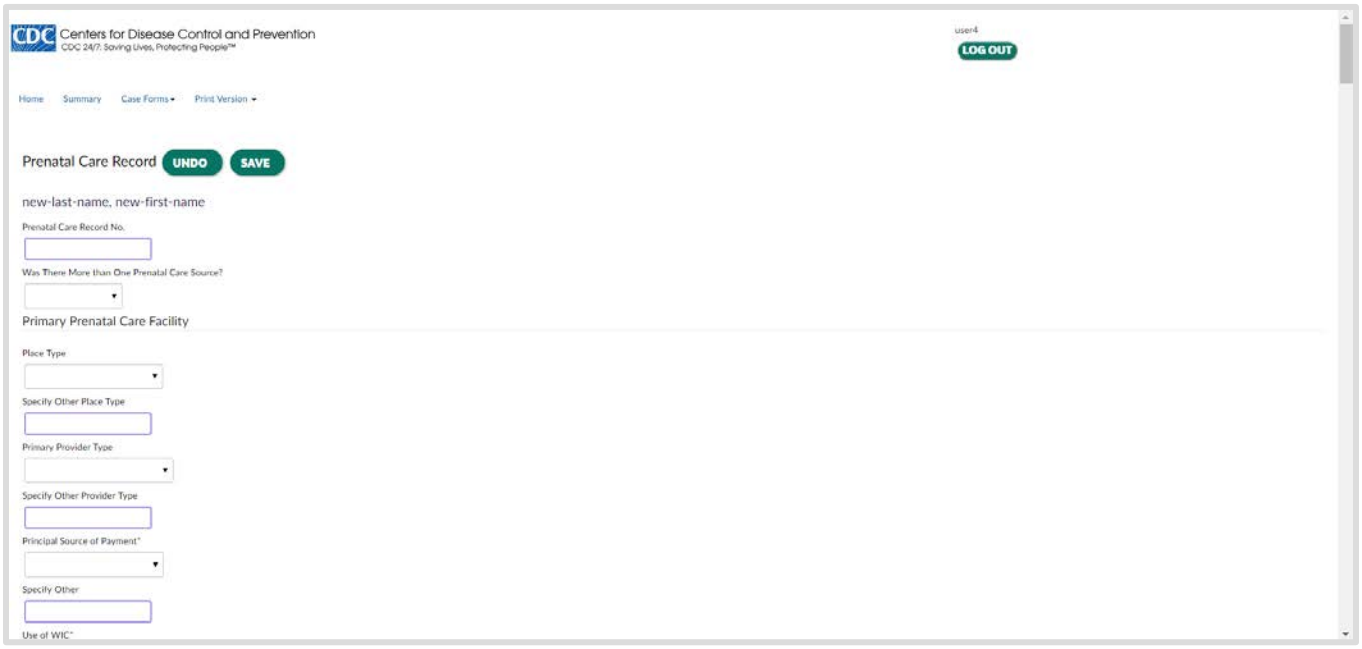


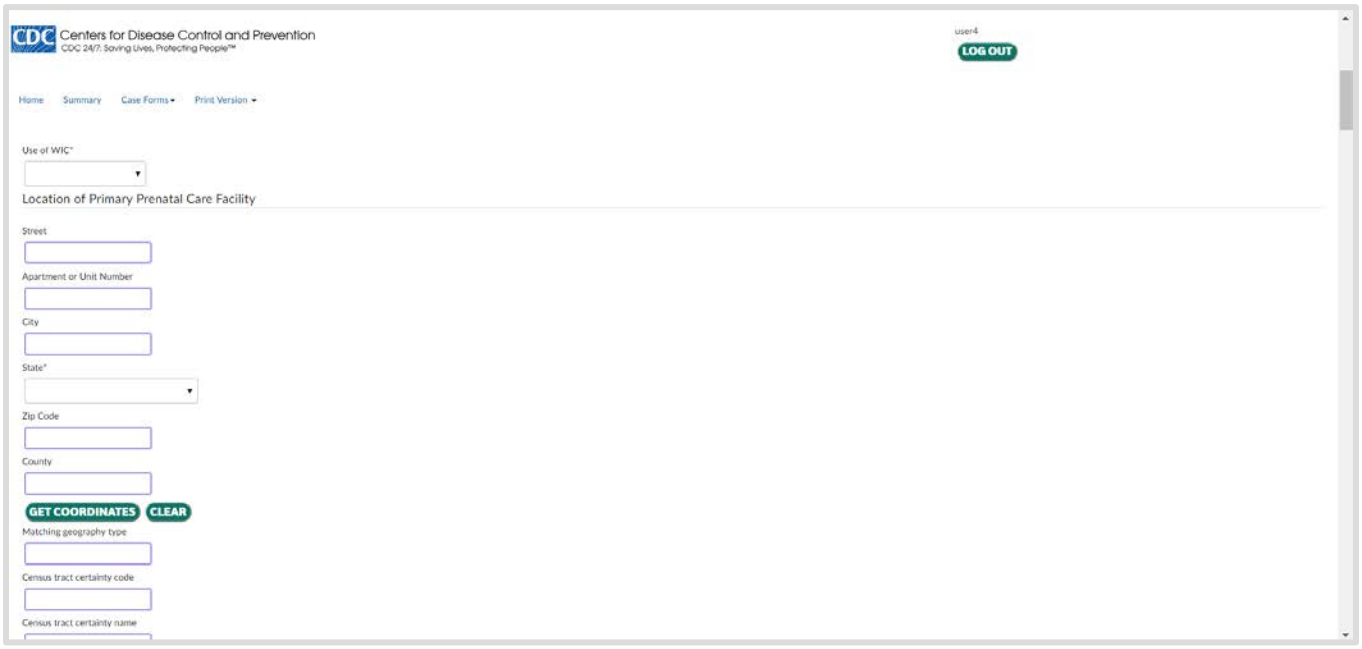


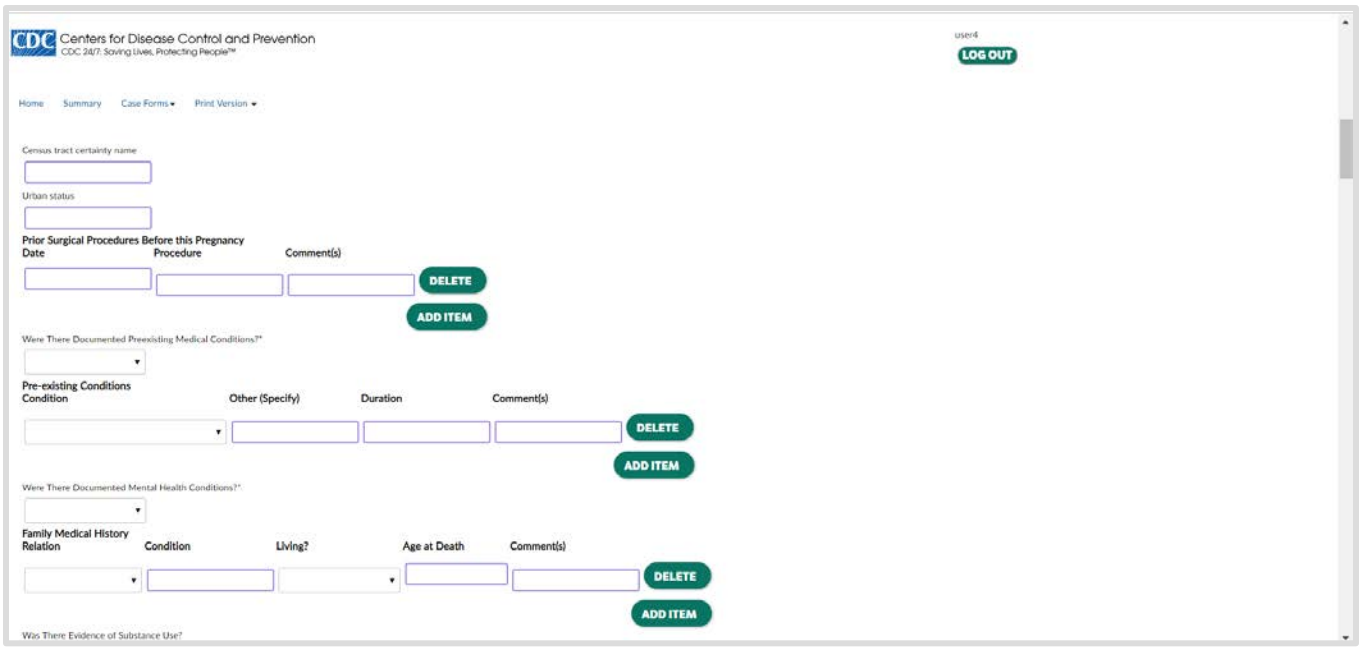

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Findings Relevant to Maternal Death
Gross Findings
Finding
Comment(s)
DELETE
ADD ITEM
Microscopic Findings
Finding
Comment(s)
DELETE
ADD ITEM
Was Toxicology Positive for Drugs?*
Toxicology*
Substance
Concentration
Unit of Measure
Level
Comment(s)
Specify Other
DELETE
ADD ITEM
ICD Code Version

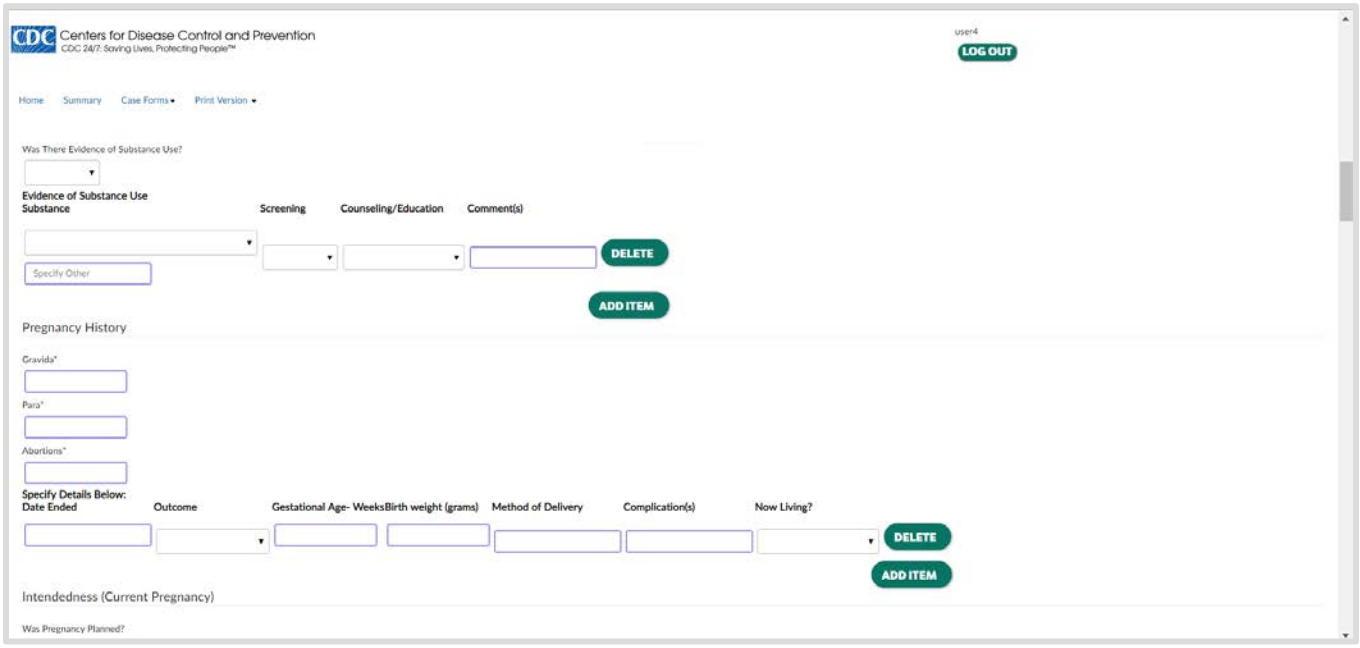

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Was Toxicology Positive for Drugs?*
Toxicology*
Substance
Concentration
Unit of Measure
Level
Comment(s)
Specify Other
DELETE
ADD ITEM
ICD Code Version
Coroner/Medical Examiner Causes of Death
Type
Cause
ICD Code
Comment(s)
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.
UNDO
SAVE

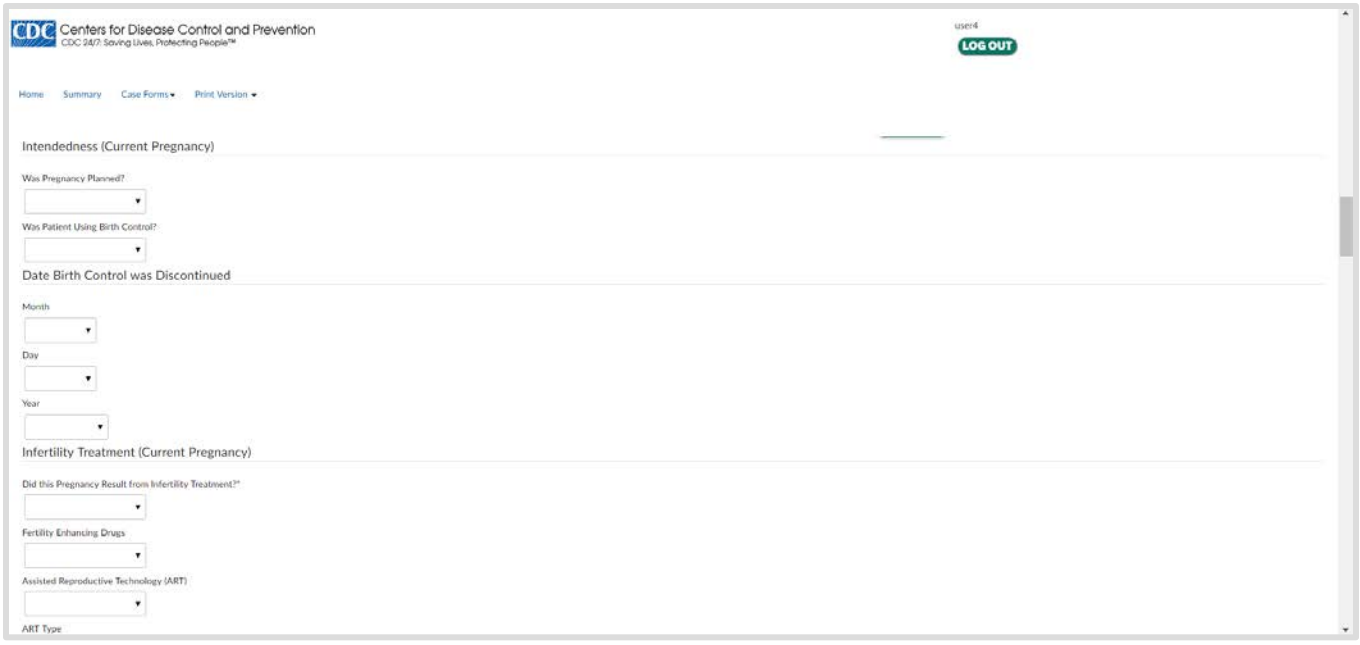
Prenatal Care Record

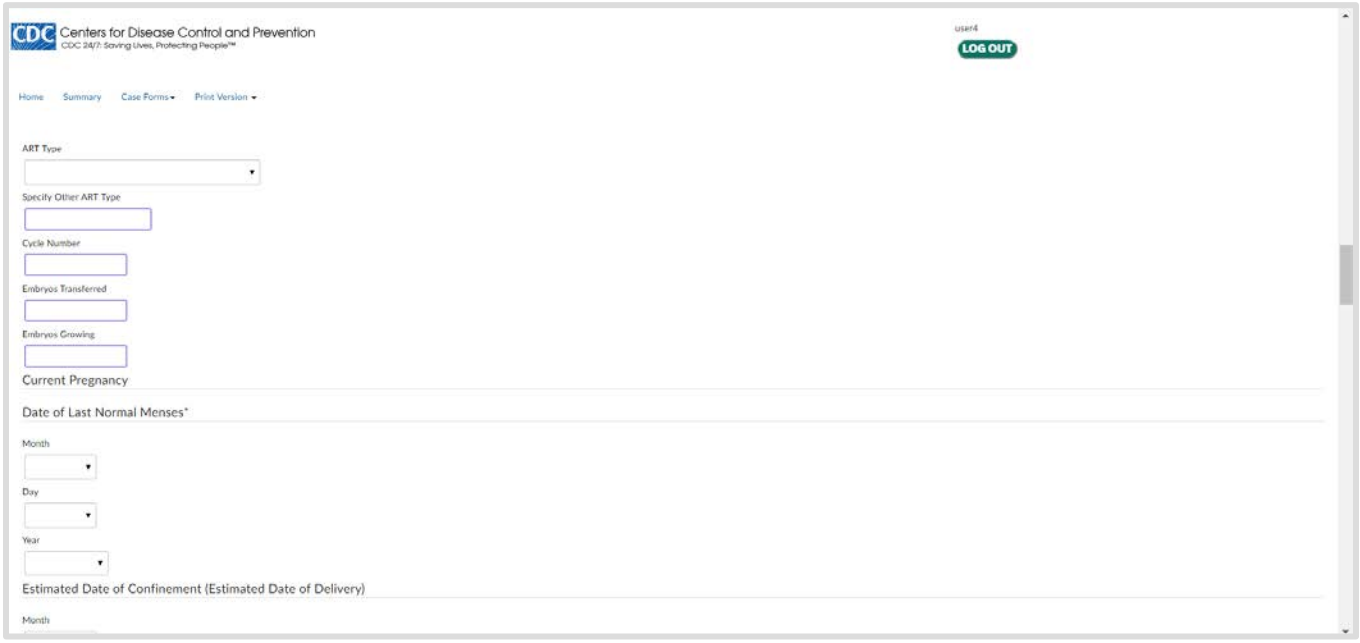


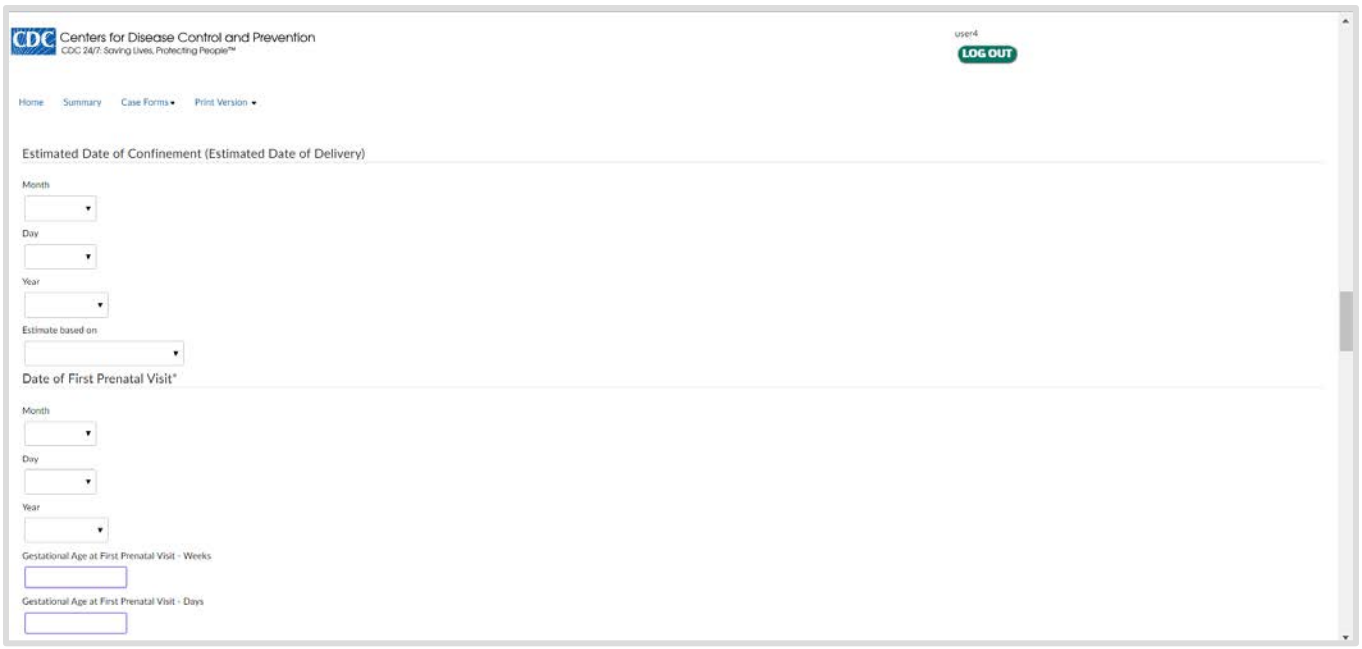


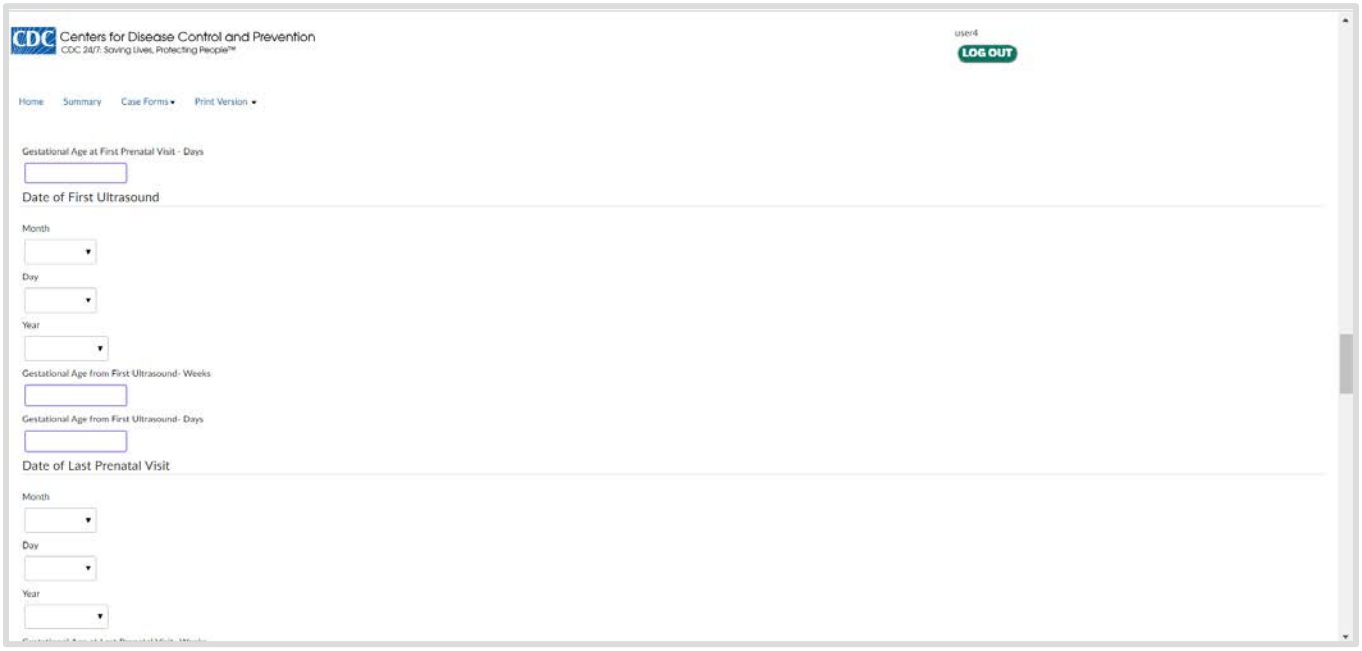

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Census tract certainty name
Urban status
Prior Surgical Procedures Before this Pregnancy
Date
Procedure
Comment(s)
DELETE
ADD ITEM
Were There Documented Preexisting Medical Conditions?*
Pre-existing Conditions
Condition
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?

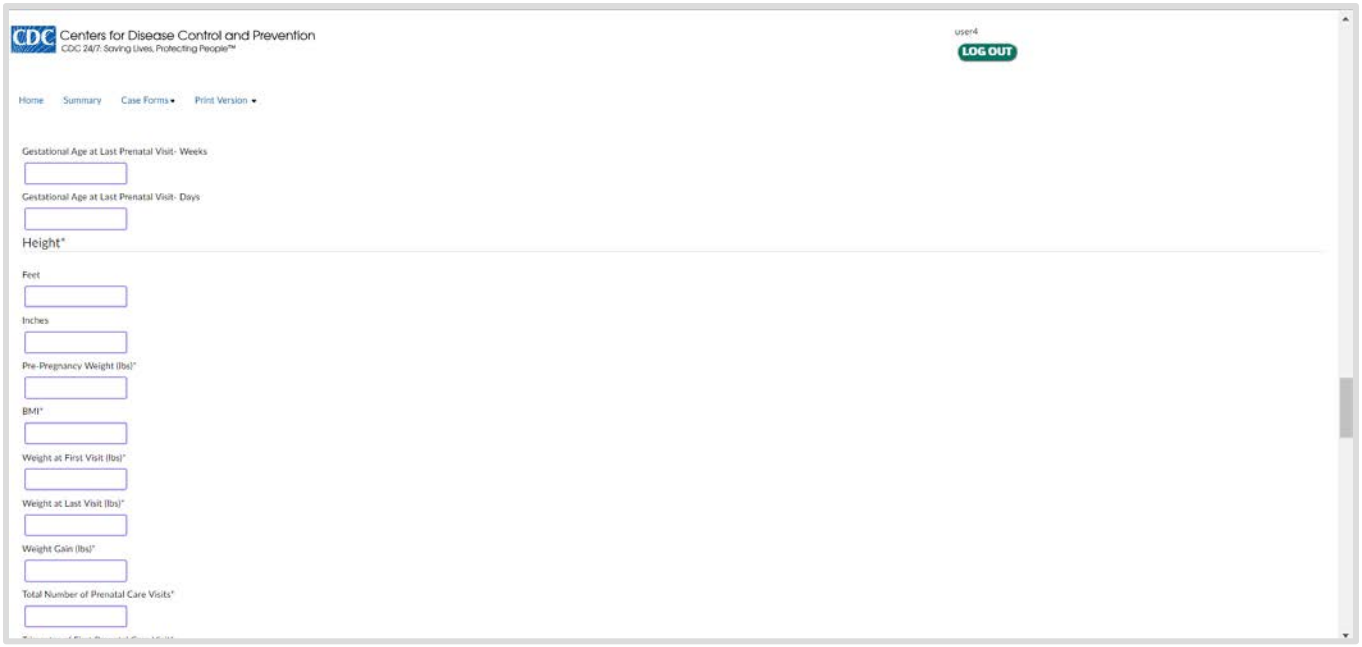

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Was There Evidence of Substance Use?
Evidence of Substance Use
Substance
Screening
Counseling/Education
Comment(s)
Specify Other
DELETE
ADD ITEM
Pregnancy History
Gravida*
Para*
Abortions*
Specify Details Below:
Date Ended
Outcome
Gestational Age- Weeks
Birth weight (grams)
Method of Delivery
Complication(s)
Now Living?
DELETE
ADD ITEM
Intendedness (Current Pregnancy)
Was Pregnancy Planned?

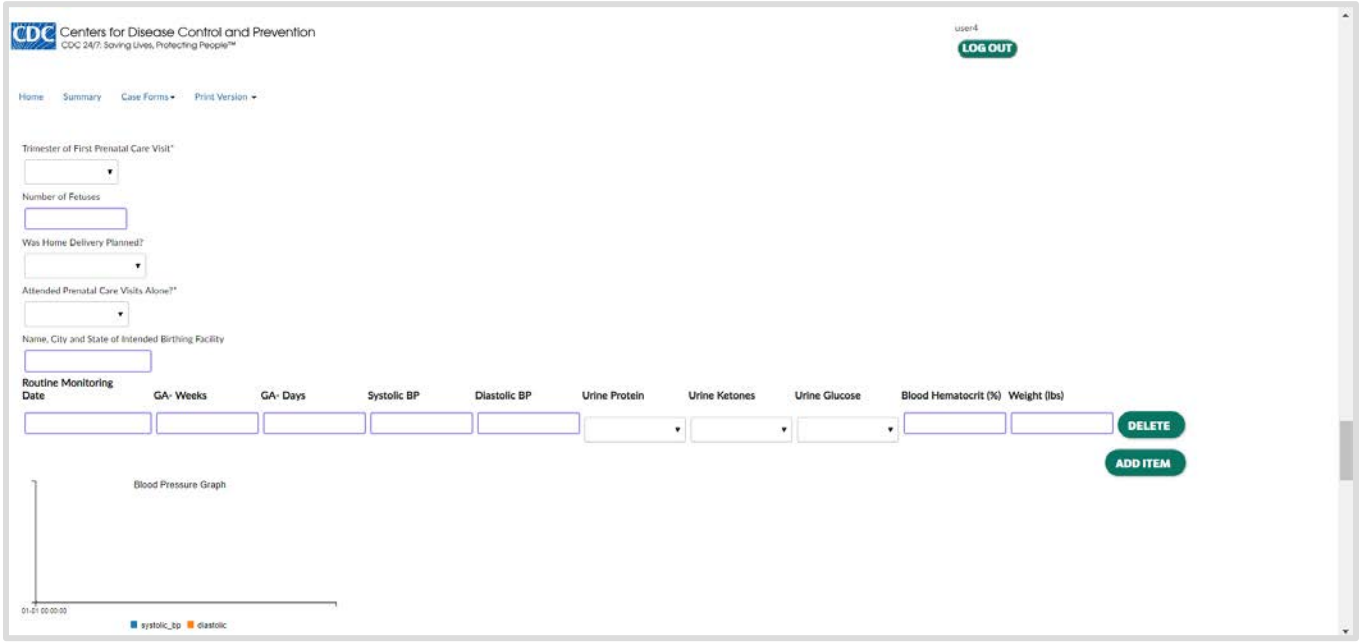

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Intendedness (Current Pregnancy)
Was Pregnancy Planned?
Was Patient Using Birth Control?
Date Birth Control was Discontinued
Month
Day
Year
Infertility Treatment (Current Pregnancy)
Did this Pregnancy Result from Infertility Treatment?*
Fertility Enhancing Drugs
Assisted Reproductive Technology (ART)
ART Type

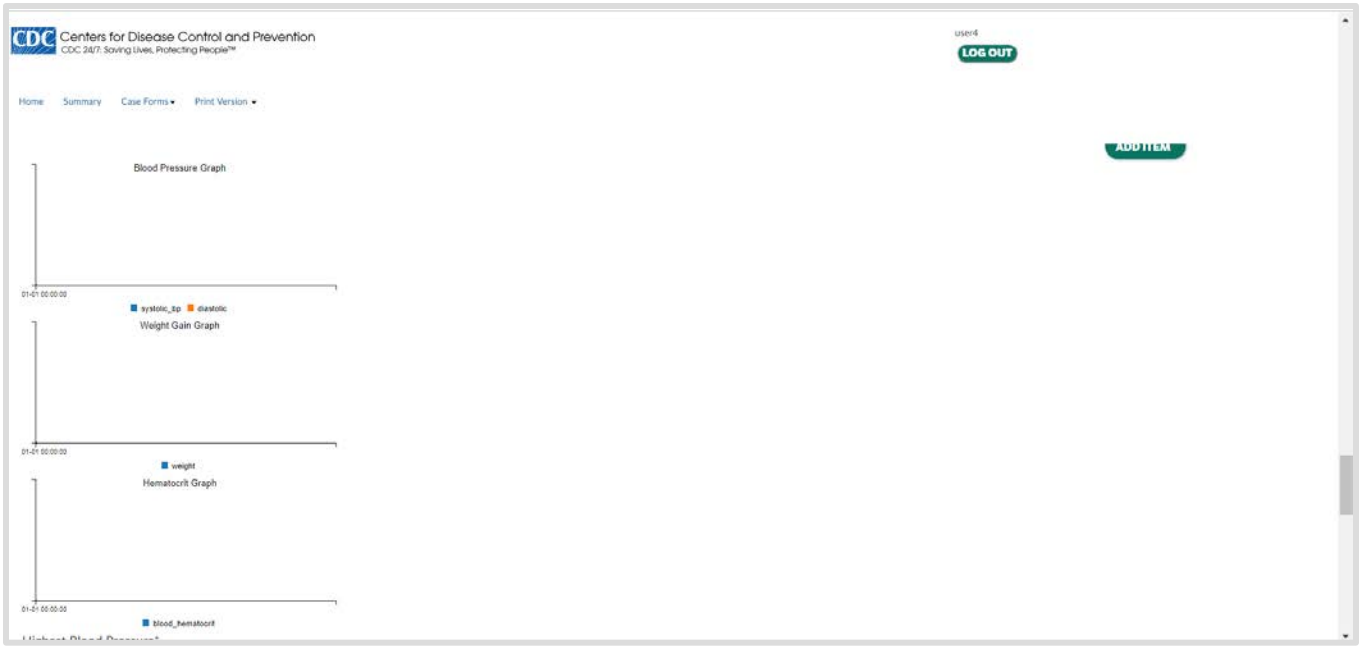

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
ART Type
Specify Other ART Type
Cycle Number
Embryos Transferred
Embryos Growing
Current Pregnancy
Date of Last Normal Menses*
Month
Day
Year
Estimated Date of Confinement (Estimated Date of Delivery)
Month

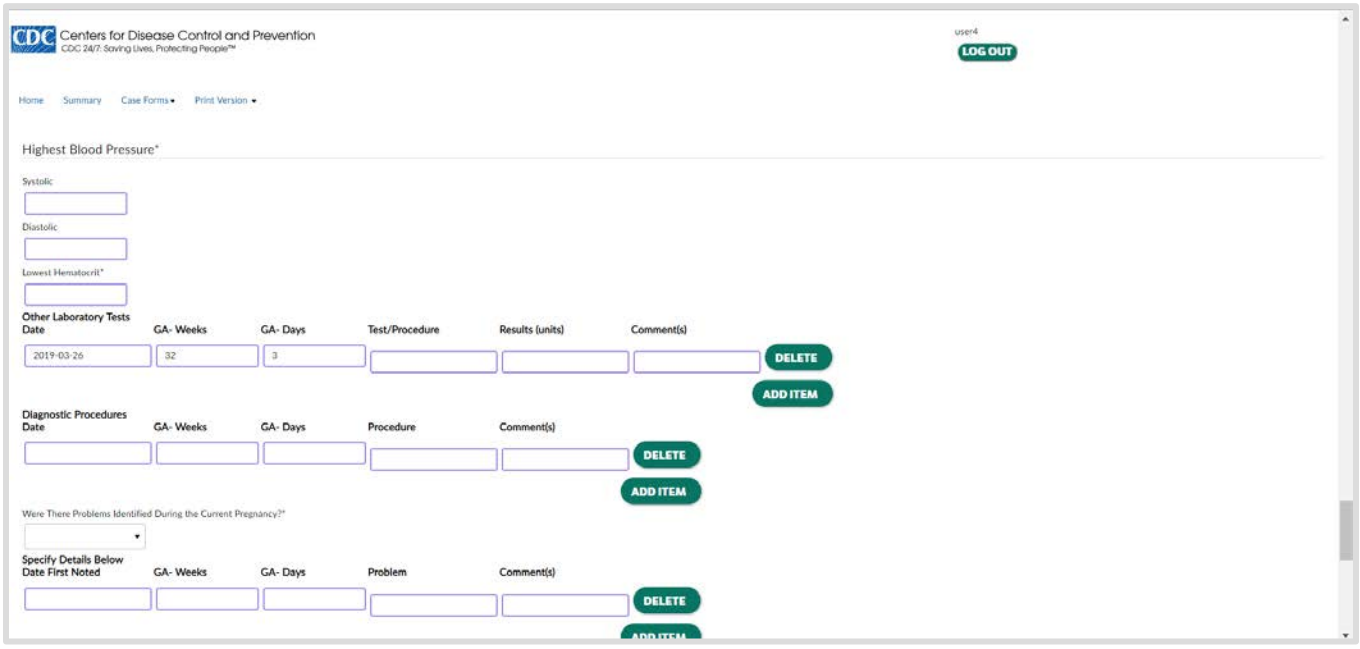

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Estimated Date of Confinement (Estimated Date of Delivery)
Month
Day
Year
Estimate based on
Date of First Prenatal Visit*
Month
Day
Year
Gestational Age at First Prenatal Visit - Weeks
Gestational Age at First Prenatal Visit - Days

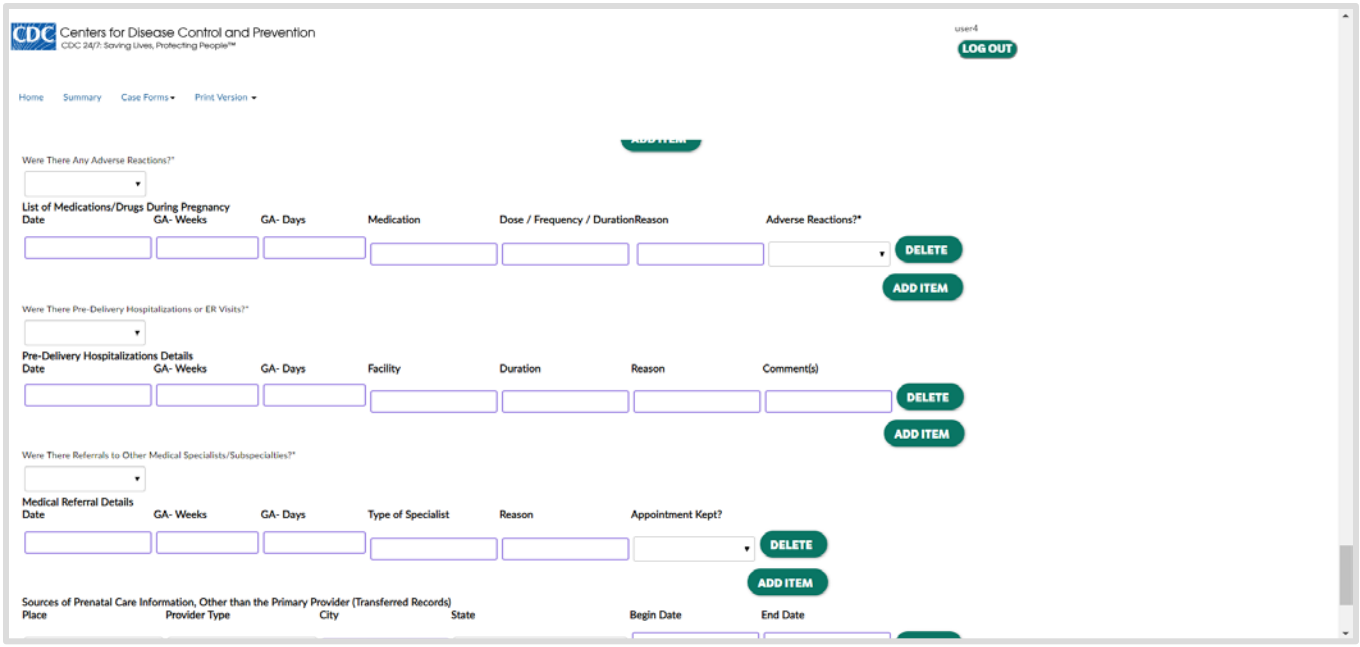

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Gestational Age at First Prenatal Visit - Days
Date of First Ultrasound
Month
Day
Year
Gestational Age from First Ultrasound- Weeks
Gestational Age from First Ultrasound- Days
Date of Last Prenatal Visit
Month
Day
Year

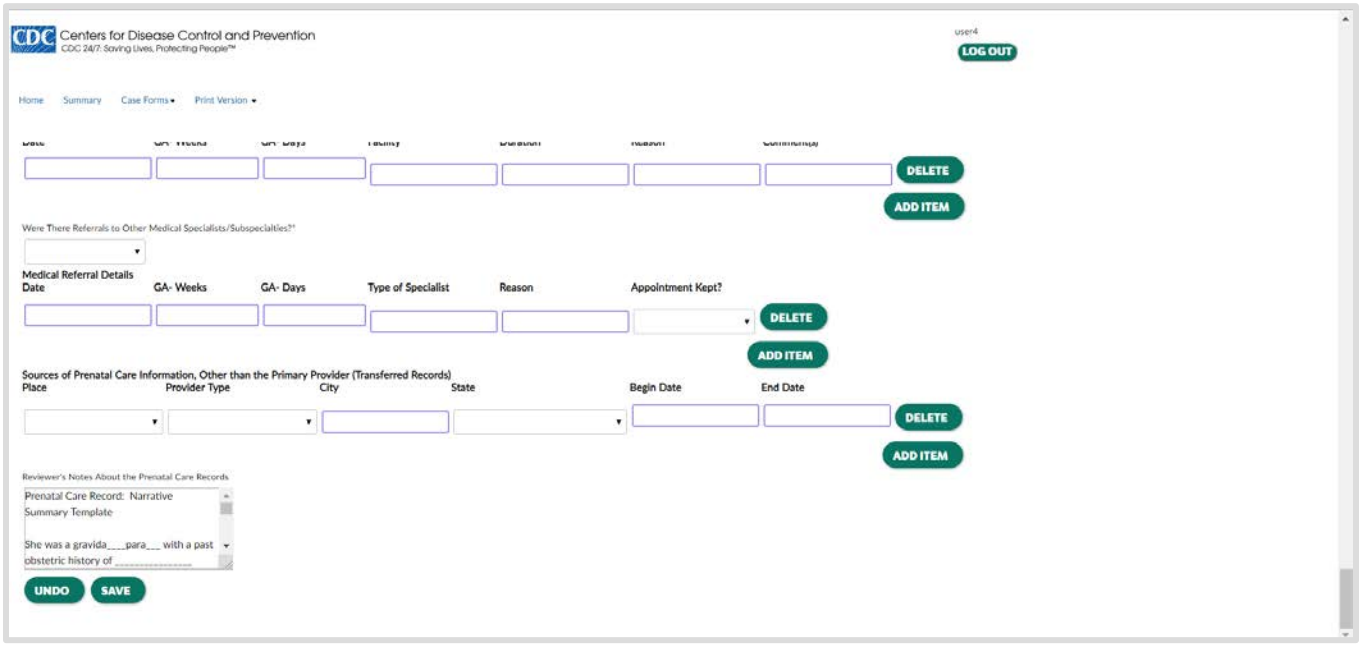

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Gestational Age at Last Prenatal Visit- Weeks
Gestational Age at Last Prenatal Visit- Days
Height*
Feet
Inches
Pre-Pregnancy Weight (lbs)*
BMI*
Weight at First Visit (lbs)*
Weight at Last Visit (lbs)*
Weight Gain (lbs)*
Total Number of Prenatal Care Visits*


Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
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
01-01 00:00:00
systolic_bp
diastolic

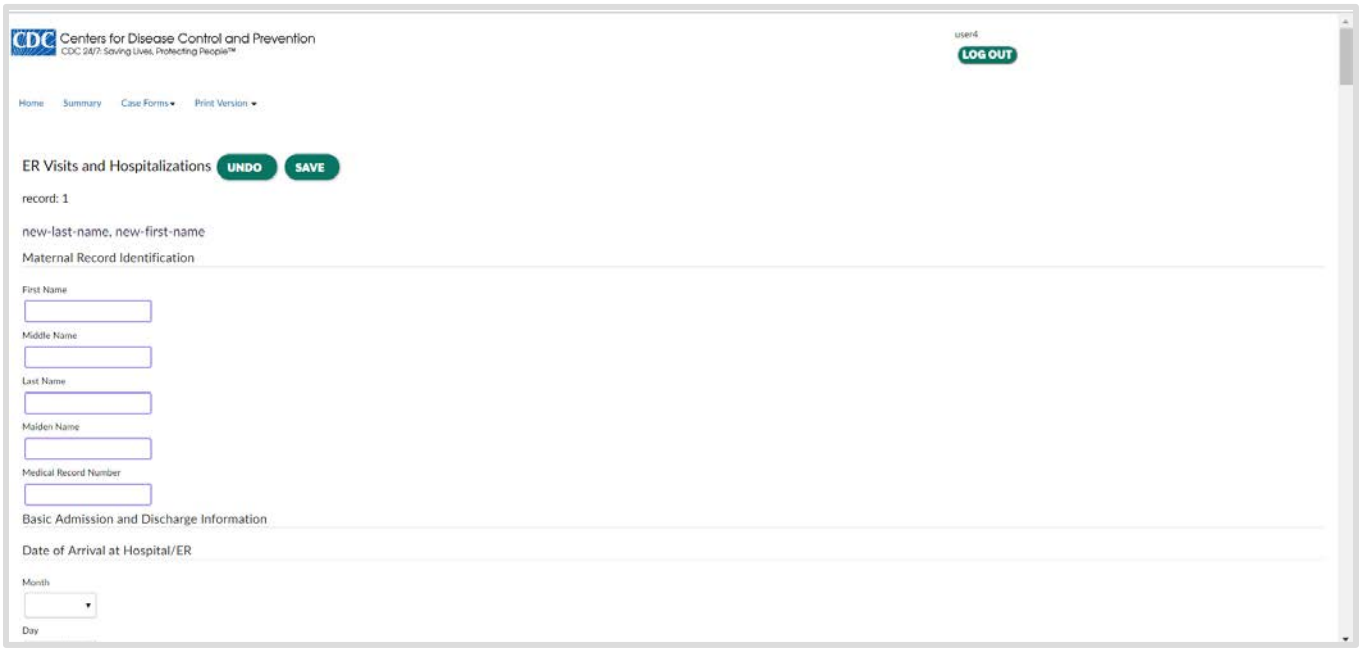

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
ADD ITEM
Blood Pressure Graph
01-01 00:00:00
systolic_bp
diastolic
Weight Gain Graph
01-01 00:00:00
weight
Hematocrit Graph
01-01 00:00:00
blood_hematocrit

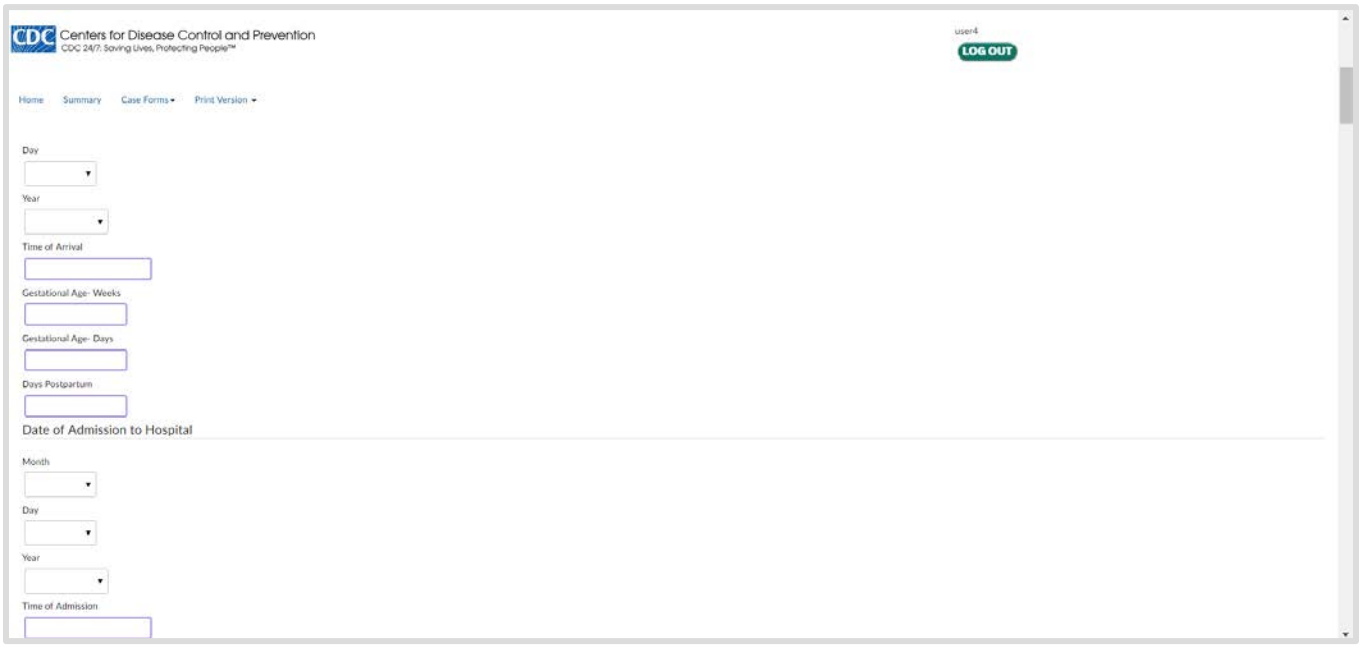

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Highest Blood Pressure*
Systolic
Diastolic
Lowest Hematocrit*
Other Laboratory Tests
Date
GA- Weeks
GA- Days
Test/Procedure
Results (units)
Comment(s)
2019-03-26
32
3
DELETE
ADD ITEM
Diagnostic Procedures
Date
GA- Weeks
GA- Days
Procedure
Comment(s)
DELETE
ADD ITEM
Were There Problems Identified During the Current Pregnancy?*
Specify Details Below
Date First Noted
GA- Weeks
GA- Days
Problem
Comment(s)
DELETE

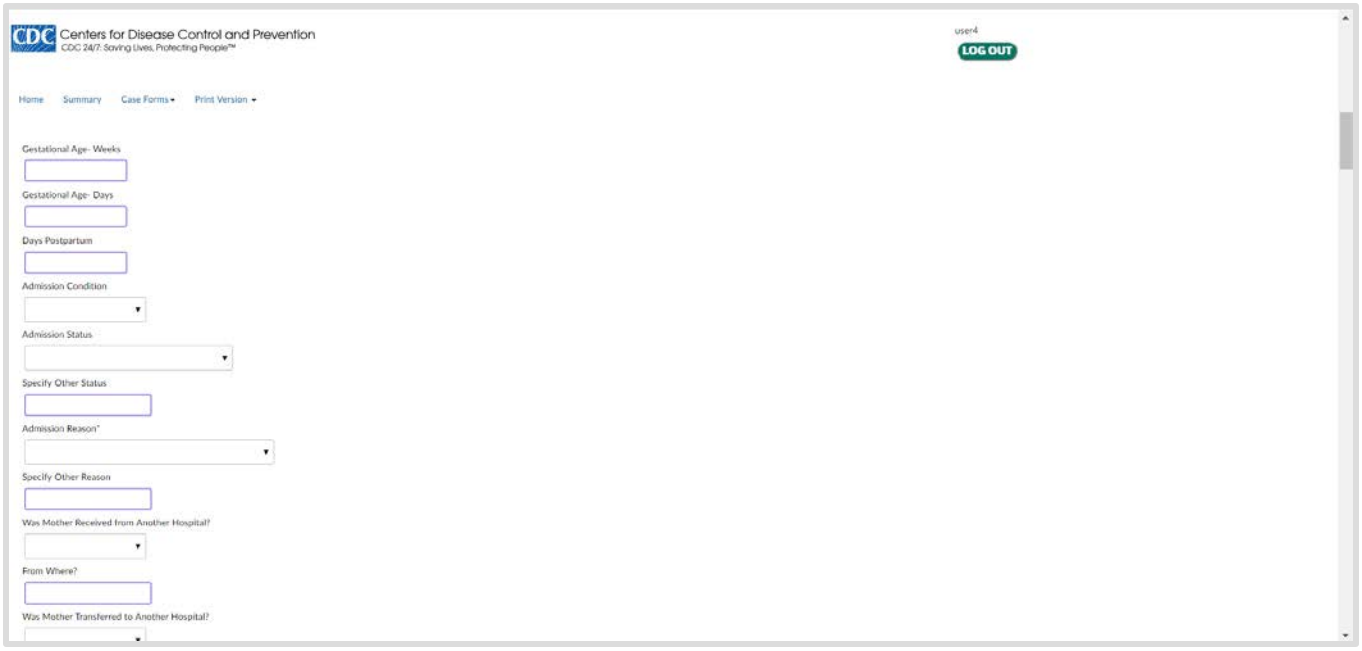

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Were There Any Adverse Reactions?*
List of Medications/Drugs During Pregnancy
Date
GA- Weeks
GA- Days
Medication
Dose / Frequency / Duration
Reason
Adverse Reactions?*
DELETE
ADD ITEM
Were There Pre-Delivery Hospitalizations or ER Visits?*
Pre-Delivery Hospitalizations Details
Date
GA- Weeks
GA- Days
Facility
Duration
Reason
Comment(s)
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?
DELETE
ADD ITEM
Sources of Prenatal Care Information, Other than the Primary Provider (Transferred Records)
Place
Provider Type
City
State
Begin Date
End Date

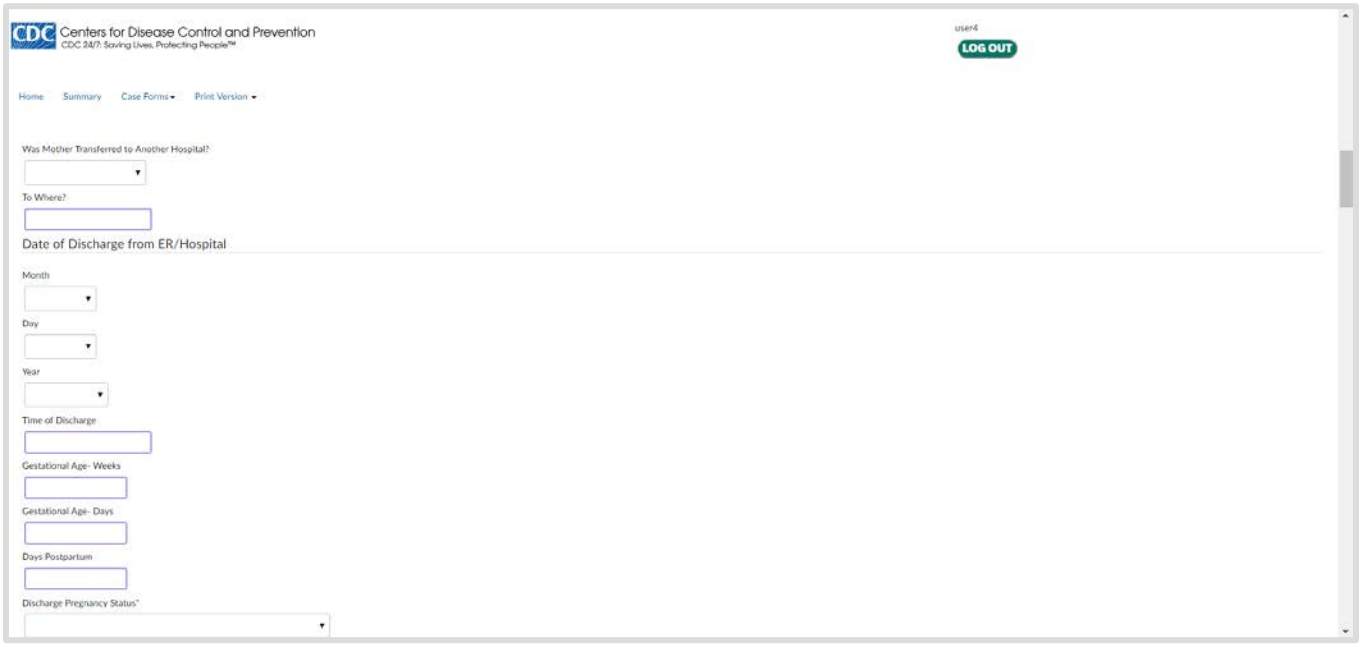

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
DELETE
ADD ITEM
Were There Referrals to Other Medical Specialists/Subspecialties?*
Medical Referral Details
Date
GA- Weeks
GA- Days
Type of Specialist
Reason
Appointment Kept?
DELETE
ADD ITEM
Sources of Prenatal Care Information, Other than the Primary Provider (Transferred Records)
Place
Provider Type
City
State
Begin Date
End Date
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 _____
UNDO
SAVE

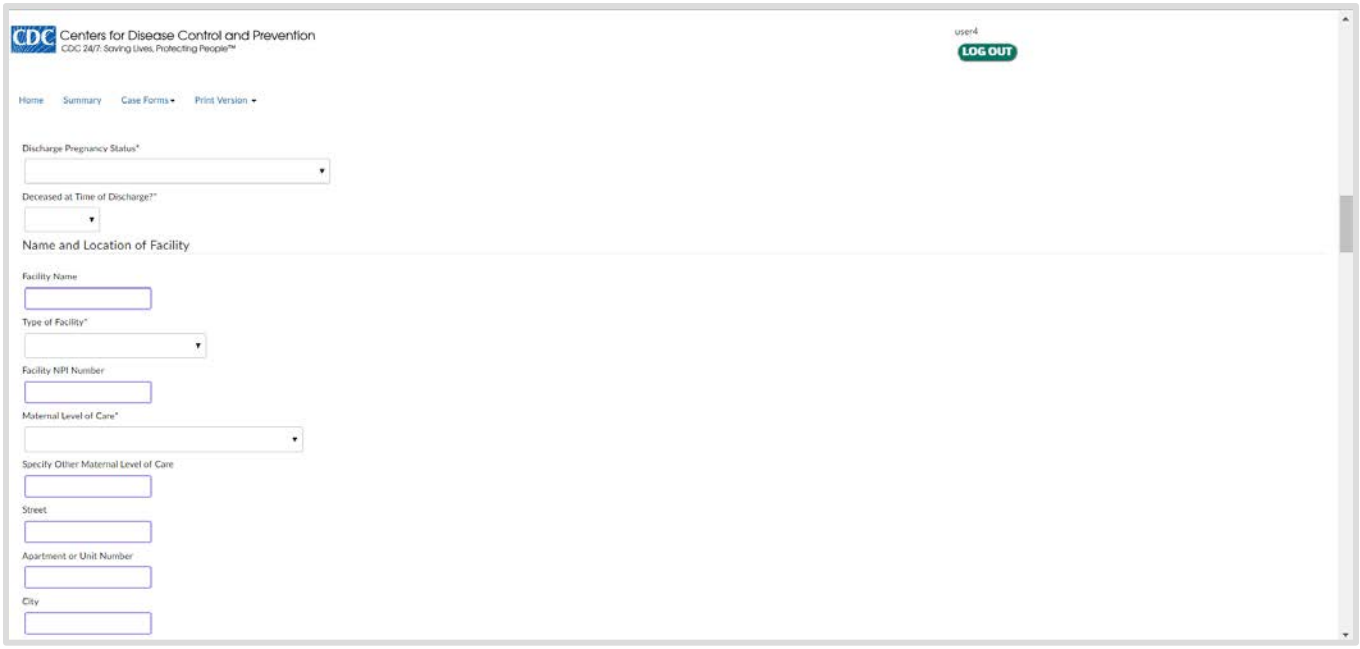
ER Visits and Hospitalizations

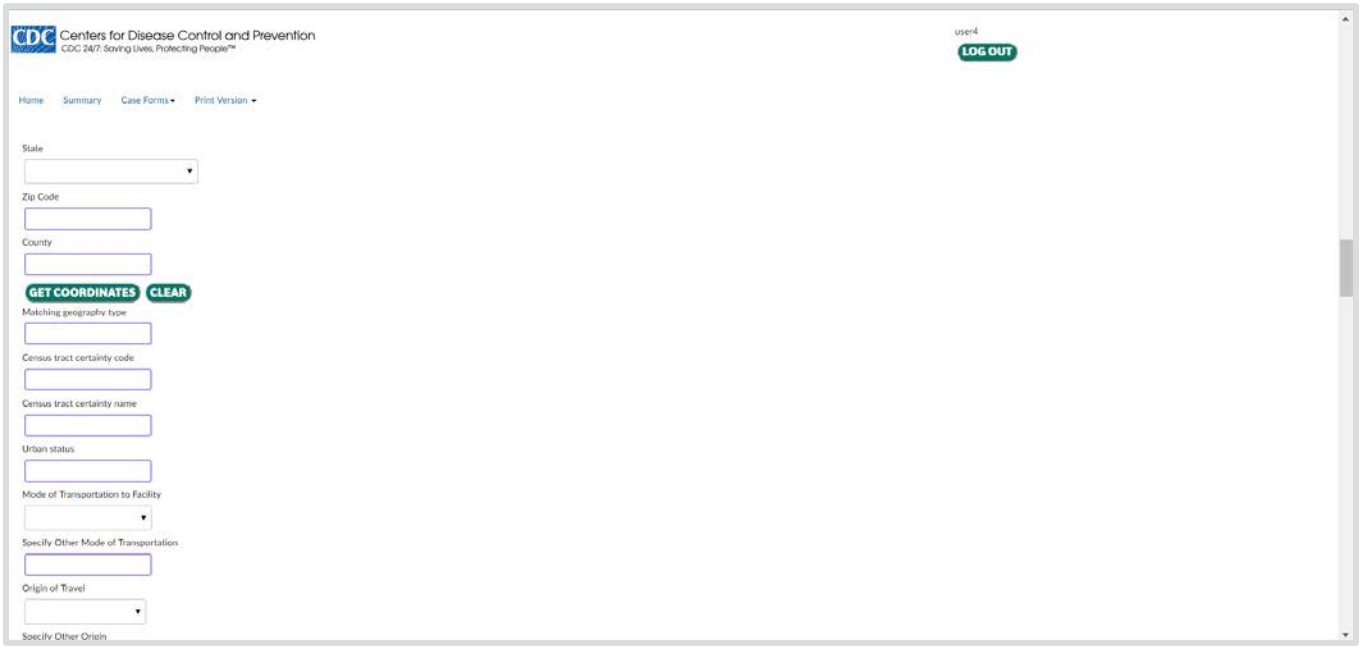


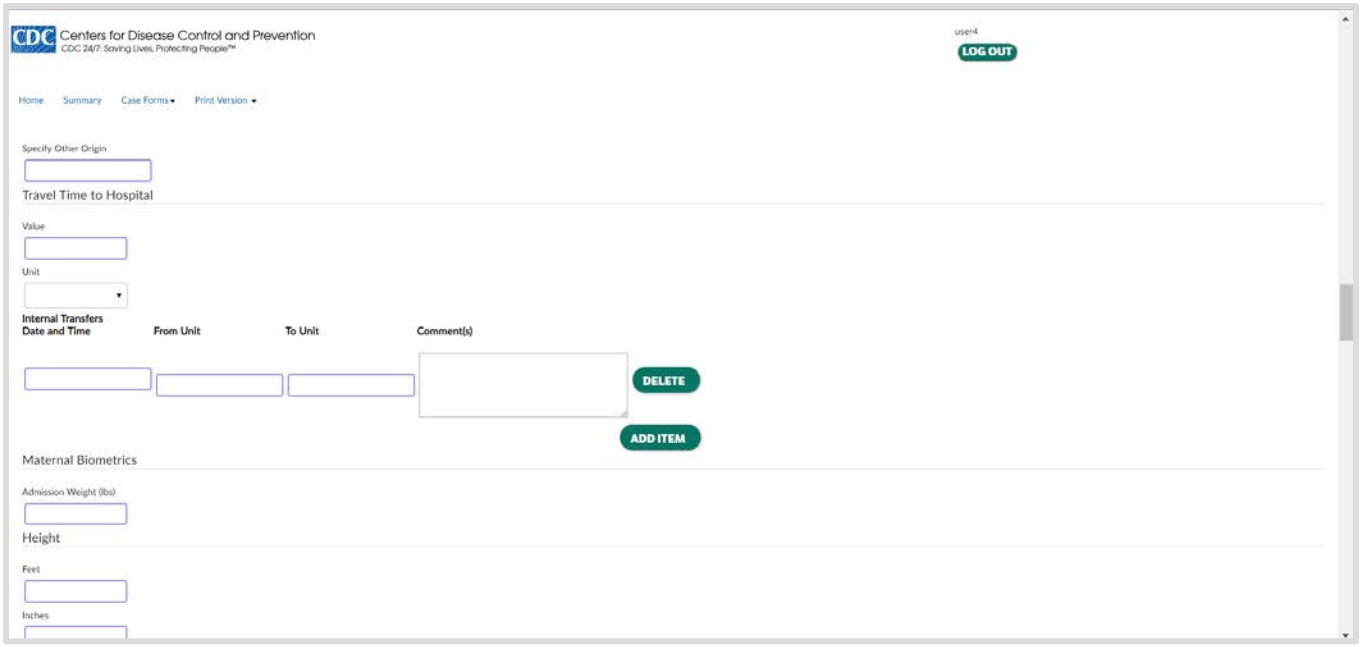


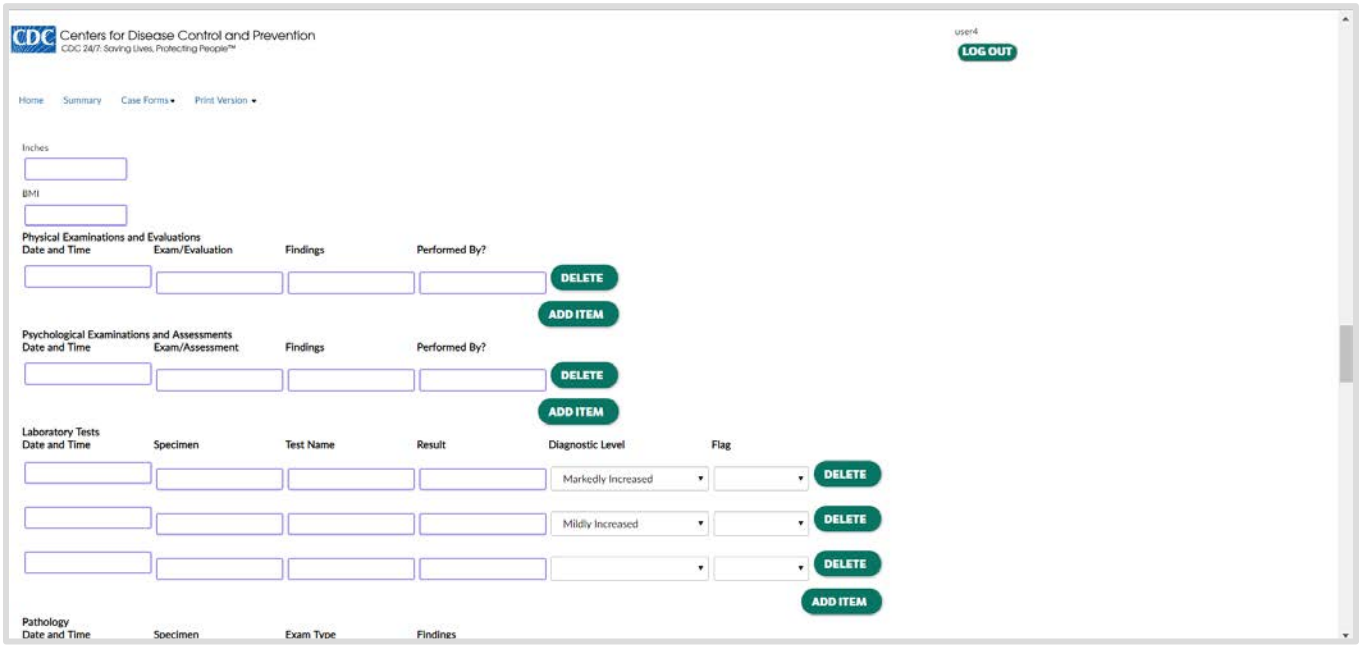

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Gestational Age- Weeks
Gestational Age- Days
Days Postpartum
Admission Condition
Admission Status
Specify Other Status
Admission Reason*
Specify Other Reason
Was Mother Received from Another Hospital?
From Where?
Was Mother Transferred to Another Hospital?

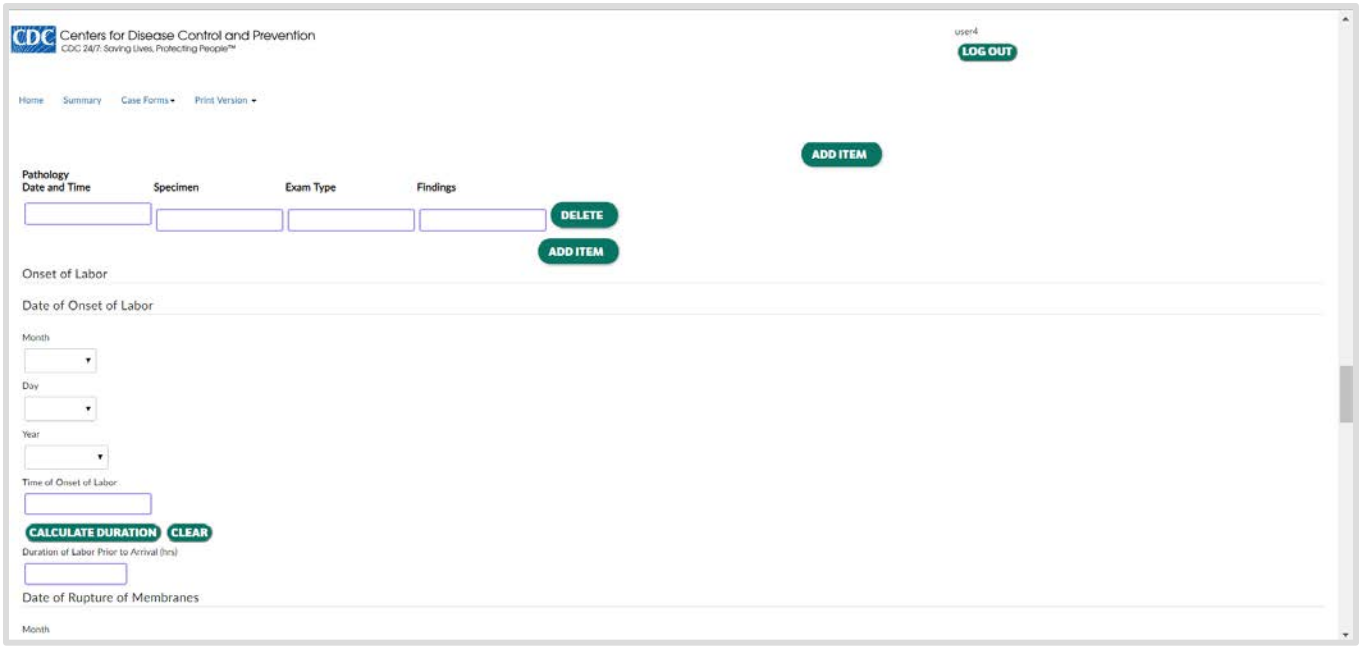

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Was Mother Transferred to Another Hospital?
To Where?
Date of Discharge from ER/Hospital
Month
Day
Year
Time of Discharge
Gestational Age- Weeks
Gestational Age- Days
Days Postpartum
Discharge Pregnancy Status*

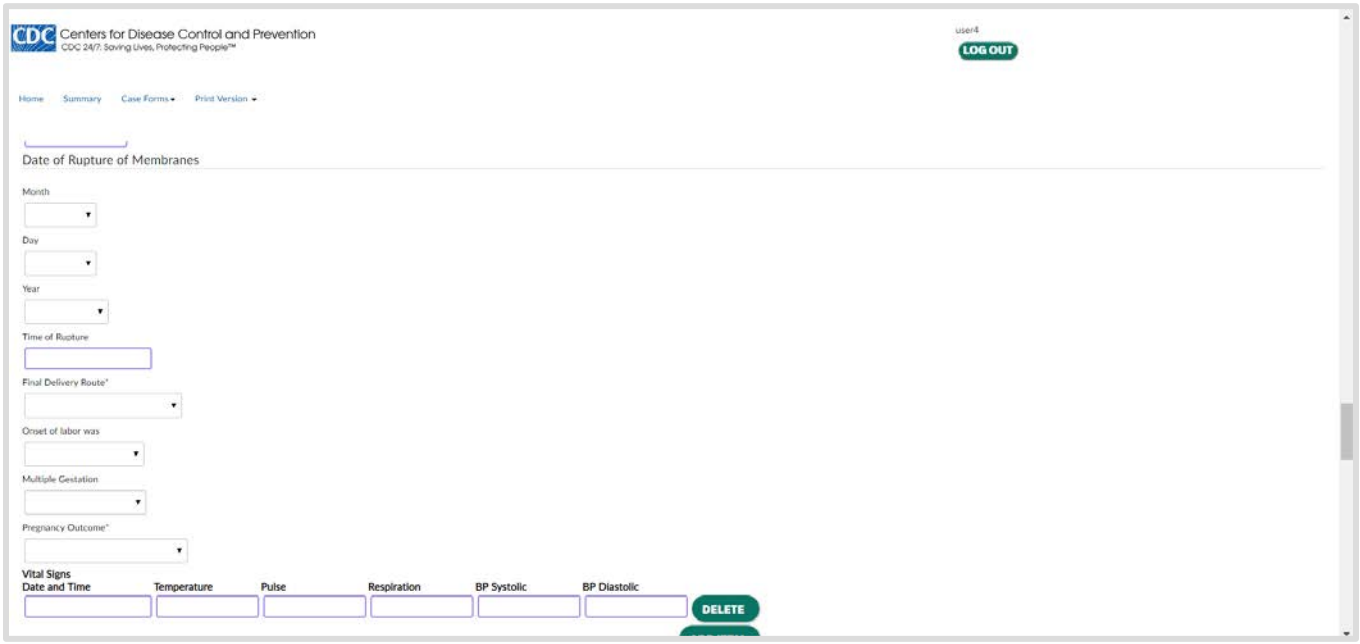

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Discharge Pregnancy Status*
Deceased at Time of Discharge?*
Name and Location of Facility
Facility Name
Type of Facility*
Facility NPI Number
Maternal Level of Care*
Specify Other Maternal Level of Care
Street
Apartment or Unit Number
City


Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
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


Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Specify Other Origin
Travel Time to Hospital
Value
Unit
Internal Transfers
Date and Time
From Unit
To Unit
Comment(s)
DELETE
ADD ITEM
Maternal Biometrics
Admission Weight (lbs)
Height
Feet
Inches

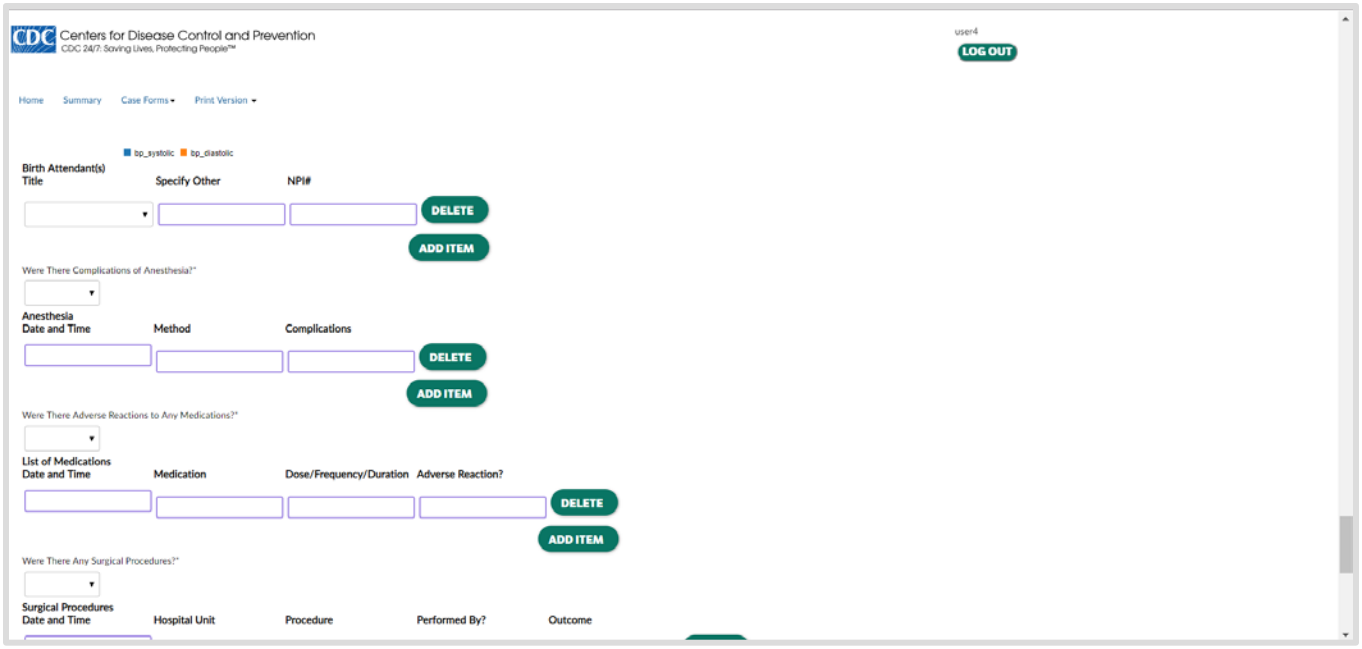

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Inches
BMI
Physical Examinations and Evaluations
Date and Time
Exam/Evaluation
Findings
Performed By?
DELETE
ADD ITEM
Psychological Examinations and Assessments
Date and Time
Exam/Assessment
Findings
Performed By?
DELETE
ADD ITEM
Laboratory Tests
Date and Time
Specimen
Test Name
Result
Diagnostic Level
Flag
Markedly Increased
Mildly Increased
DELETE
ADD ITEM
Pathology
Date and Time
Specimen
Exam Type
Findings

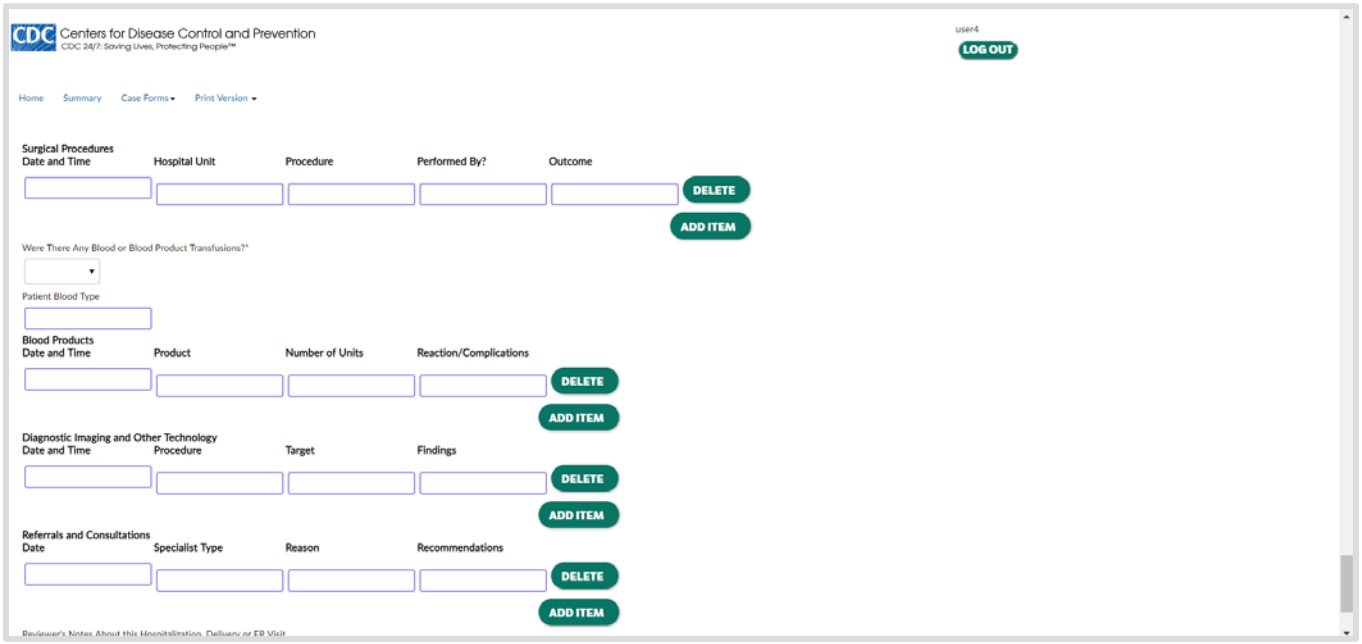

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
ADD ITEM
Pathology
Date and Time
Specimen
Exam Type
Findings
DELETE
ADD ITEM
Onset of Labor
Date of Onset of Labor
Month
Day
Year
Time of Onset of Labor
CALCULATE DURATION
CLEAR
Duration of Labor Prior to Arrival (hrs)
Date of Rupture of Membranes
Month

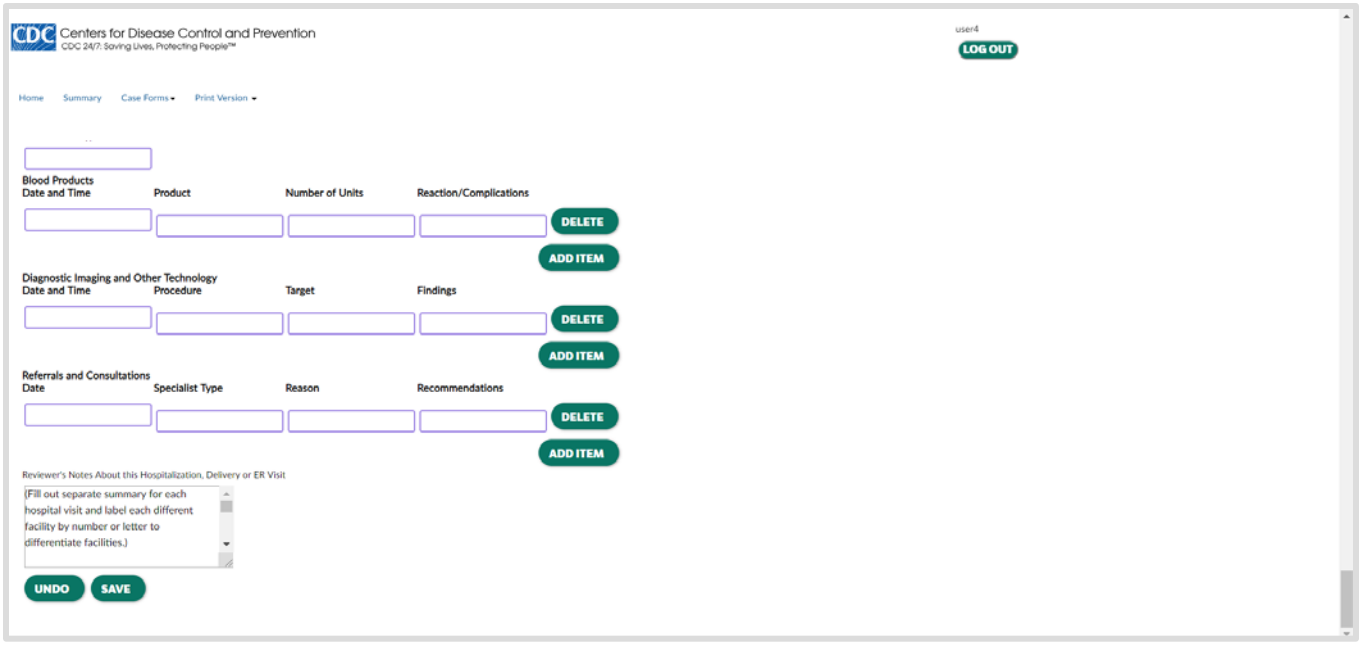

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Date of Rupture of Membranes
Month
Day
Year
Time of Rupture
Final Delivery Route*
Onset of labor was
Multiple Gestation
Pregnancy Outcome*
Vital Signs
Date and Time
Temperature
Pulse
Respiration
BP Systolic
BP Diastolic
DELETE


Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Highest BP
Systolic BP*
Diastolic BP*
Temperature Graph
01-01 00:00:00
temperature
Pulse Graph
01-01 00:00:00
pulse
Respiration Graph

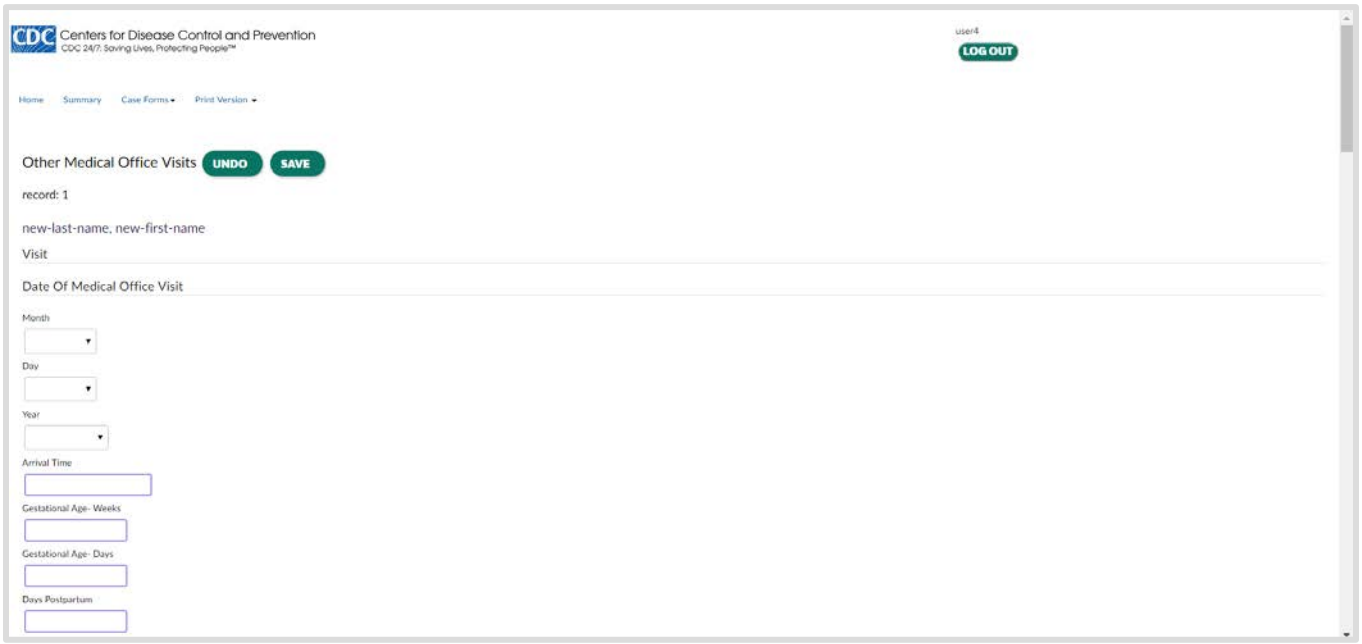

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
01-01 00:00:00
temperature
Pulse Graph
01-01 00:00:00
pulse
Respiration Graph
01-01 00:00:00
respiration
Blood Pressure Graph
01-01 00:00:00
bp_systolic
bp_diastolic

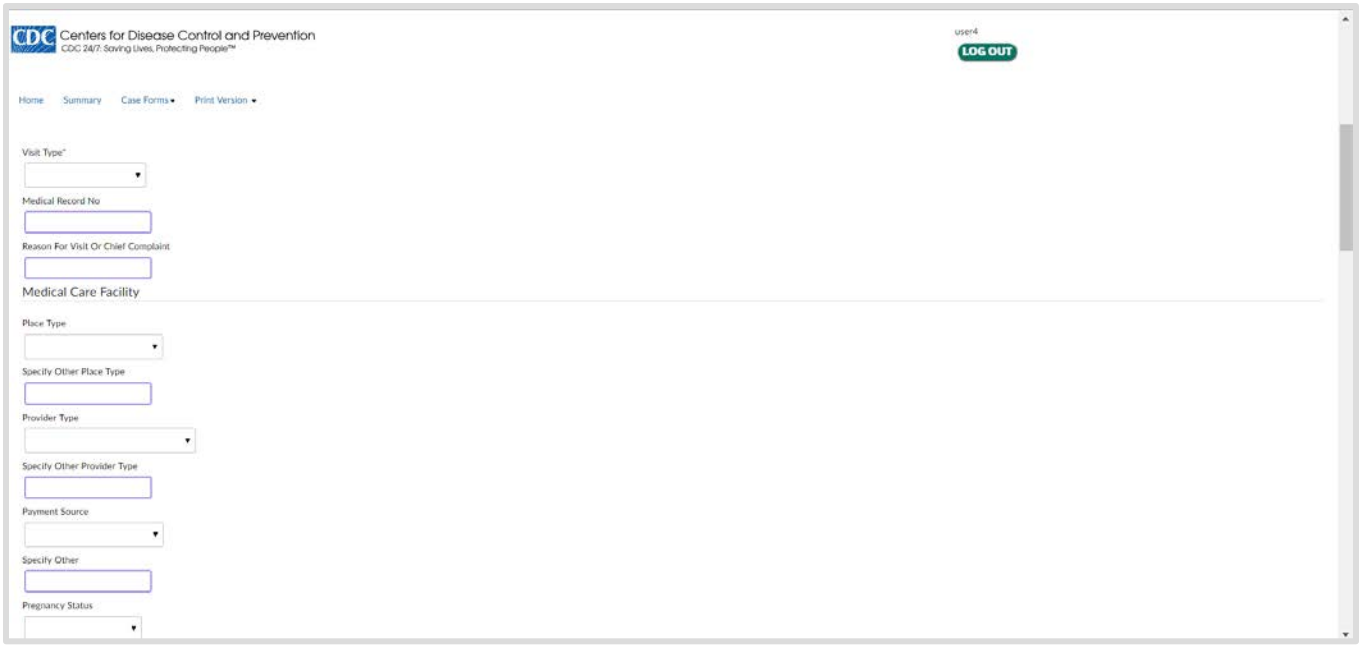

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
bp_systolic
bp_diastolic
Birth Attendant(s)
Title
Specify Other
NPI#
DELETE
ADD ITEM
Were There Complications of Anesthesia?*
Anesthesia
Date and Time
Method
Complications
DELETE
ADD ITEM
Were There Adverse Reactions to Any Medications?*
List of Medications
Date and Time
Medication
Dose/Frequency/Duration
Adverse Reaction?
DELETE
ADD ITEM
Were There Any Surgical Procedures?*
Surgical Procedures
Date and Time
Hospital Unit
Procedure
Performed By?
Outcome

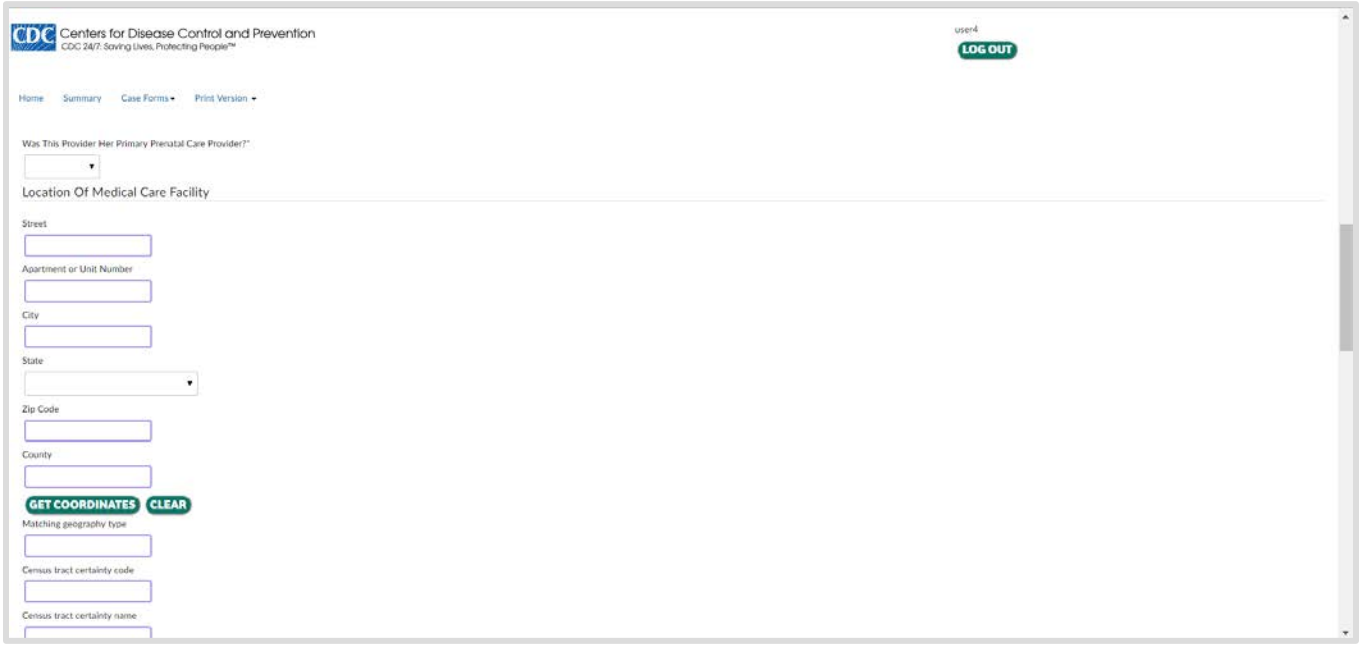

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Surgical Procedures
Date and Time
Hospital Unit
Procedure
Performed By?
Outcome
DELETE
ADD ITEM
Were There Any Blood or Blood Product Transfusions?*
Patient Blood Type
Blood Products
Date and Time
Product
Number of Units
Reaction/Complications
DELETE
ADD ITEM
Diagnostic Imaging and Other Technology
Date and Time
Procedure
Target
Findings
DELETE
ADD ITEM
Referrals and Consultations
Date
Specialist Type
Reason
Recommendations
DELETE
ADD ITEM
Reviewer's Notes About this Hospitalization, Delivery or ER Visit

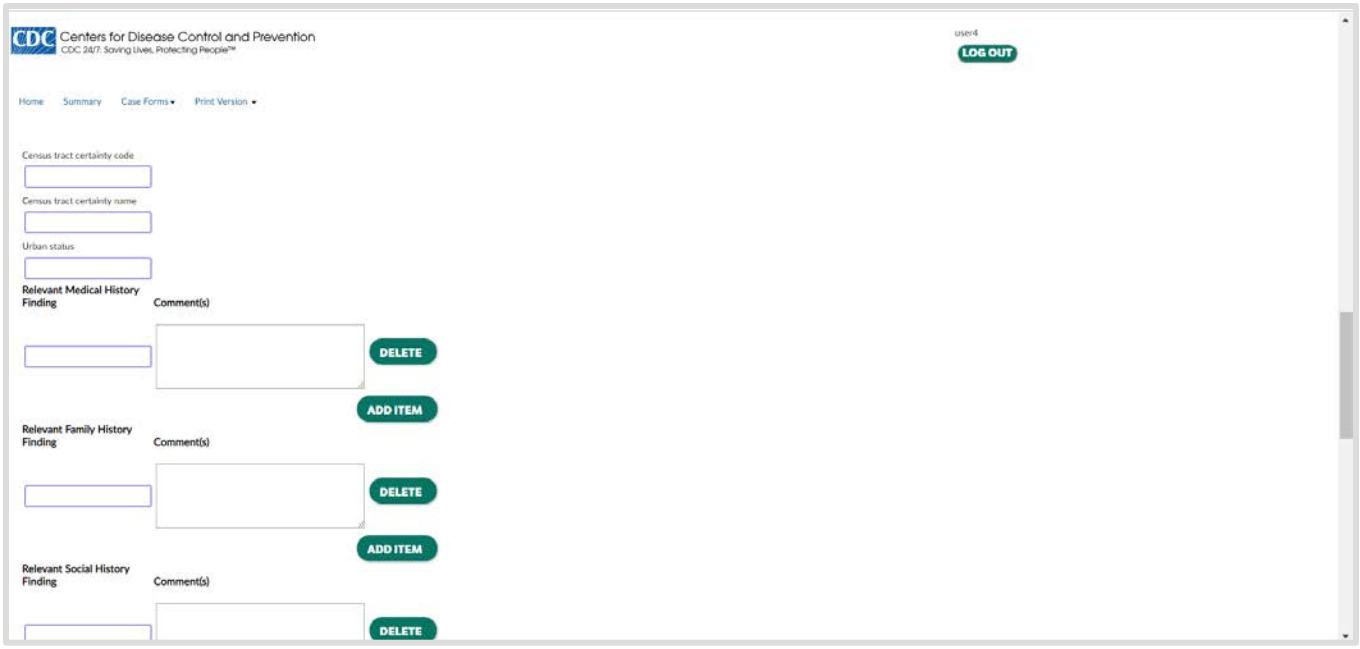


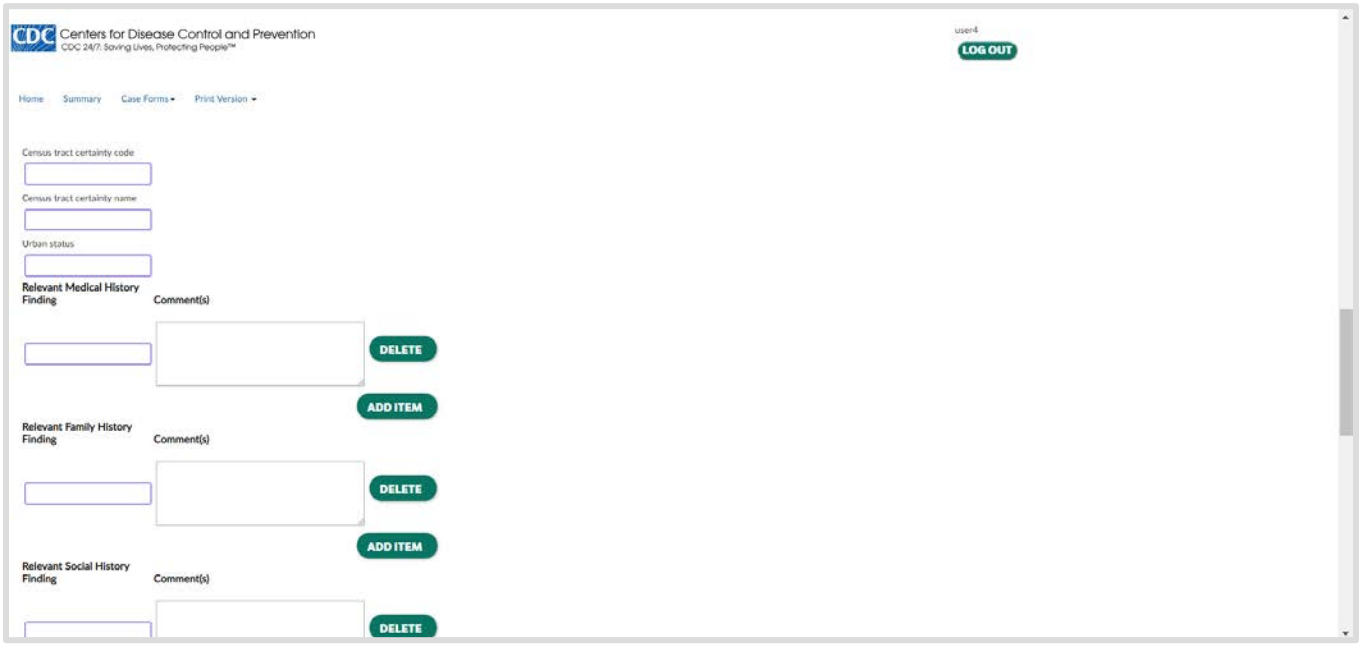
Other Medical Office Visits

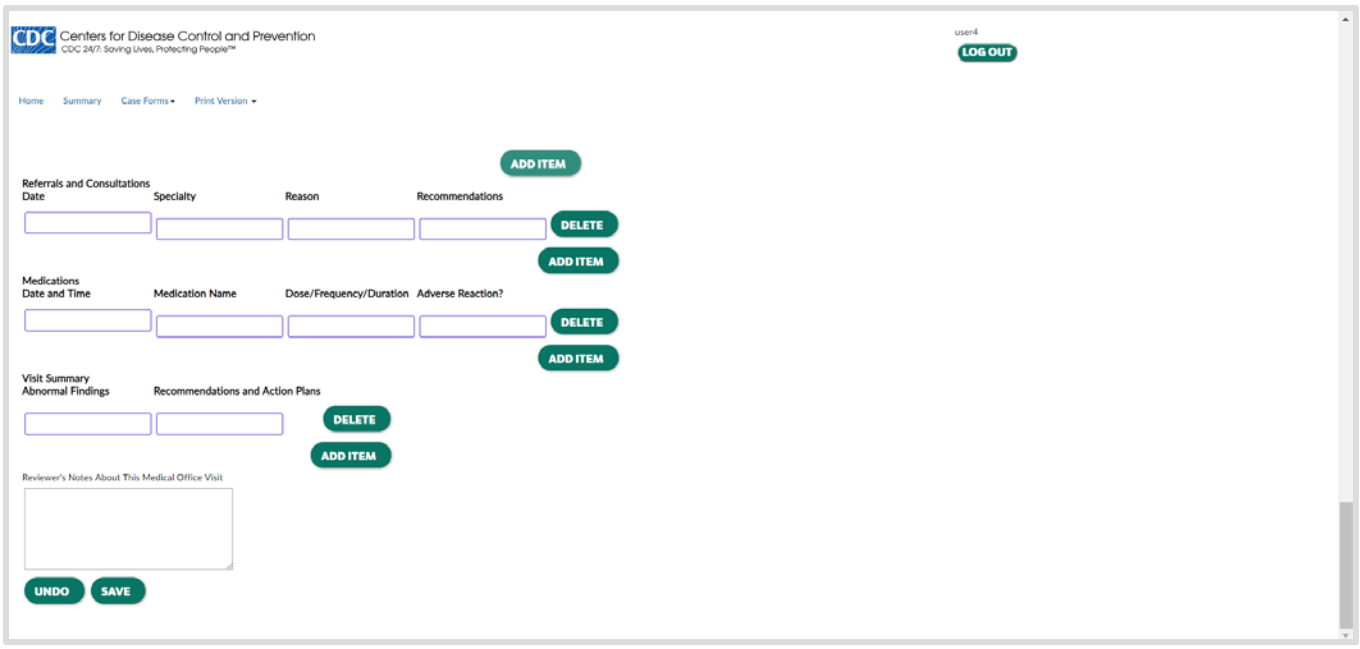



Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Visit Type*
Medical Record No
Reason For Visit Or Chief Complaint
Medical Care Facility
Place Type
Specify Other Place Type
Provider Type
Specify Other Provider Type
Payment Source
Specify Other
Pregnancy Status

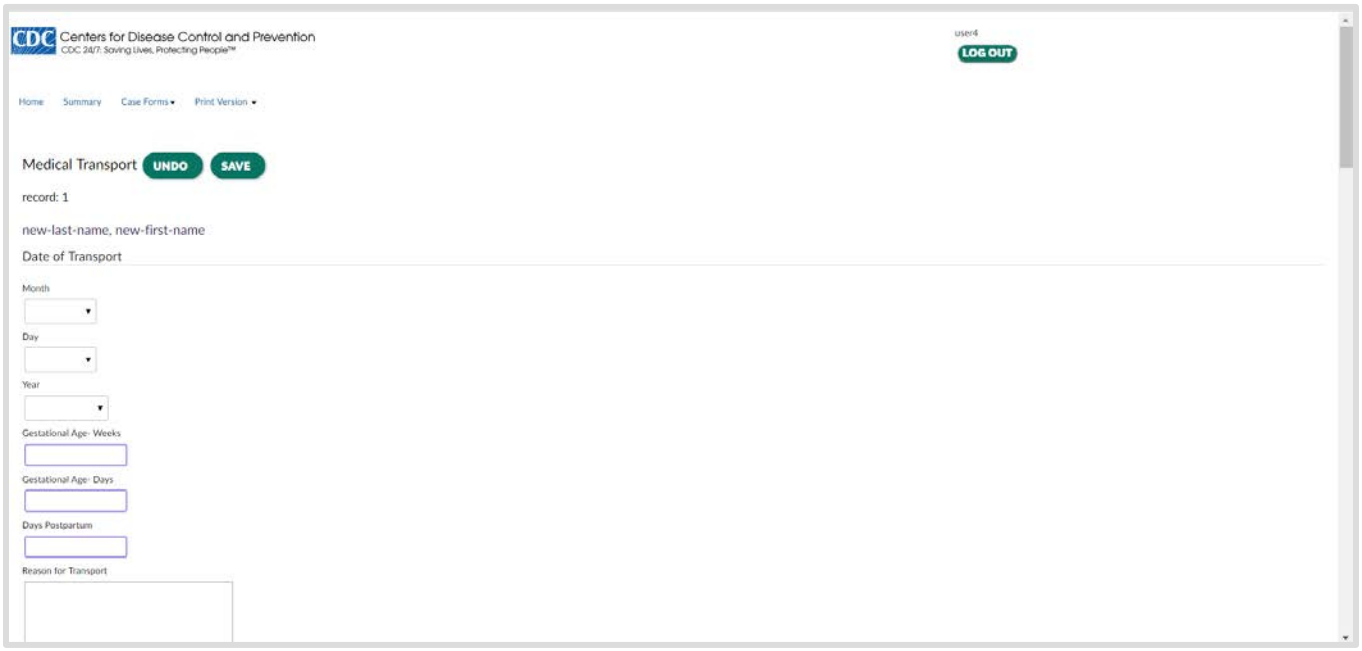

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Was This Provider Her Primary Prenatal Care Provider?*
Location Of Medical Care Facility
Street
Apartment or Unit Number
City
State
Zip Code
County
GET COORDINATES
CLEAR
Matching geography type
Census tract certainty code
Census tract certainty name

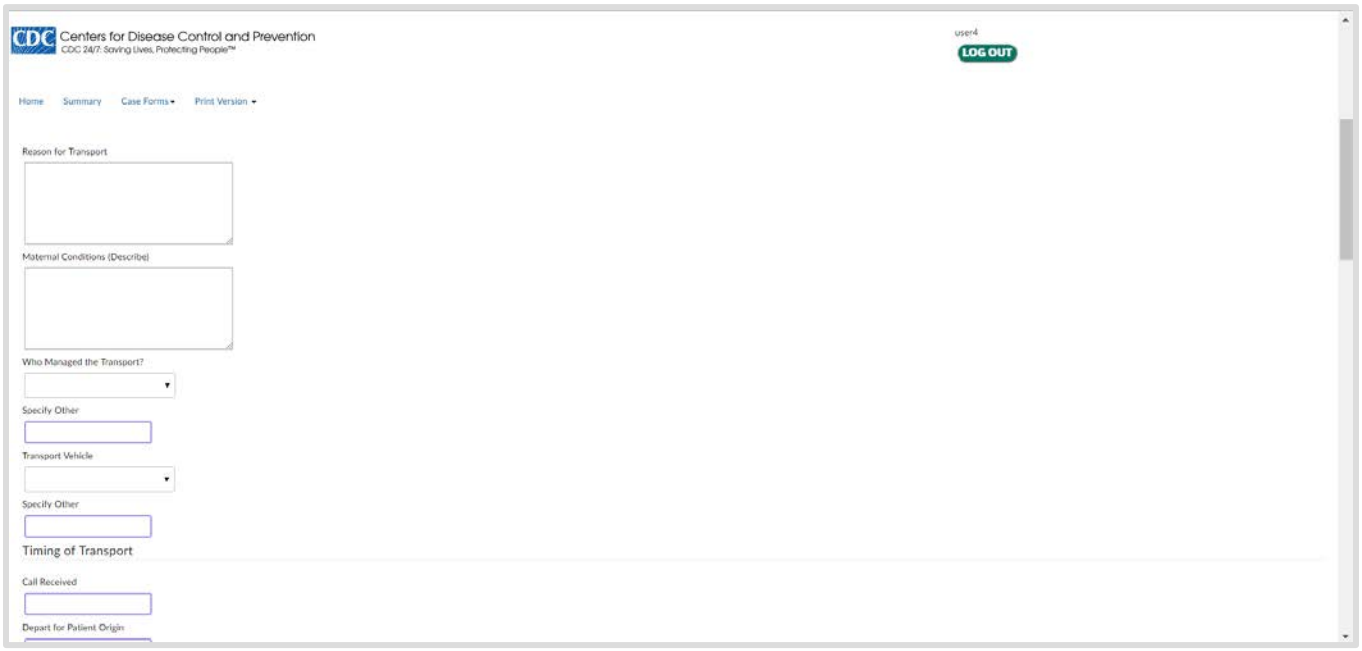

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Census tract certainty code
Census tract certainty name
Urban status
Relevant Medical History Finding
Comment(s)
DELETE
ADD ITEM
Relevant Family History Finding
Comment(s)
DELETE
ADD ITEM
Relevant Social History Finding
Comment(s)
DELETE

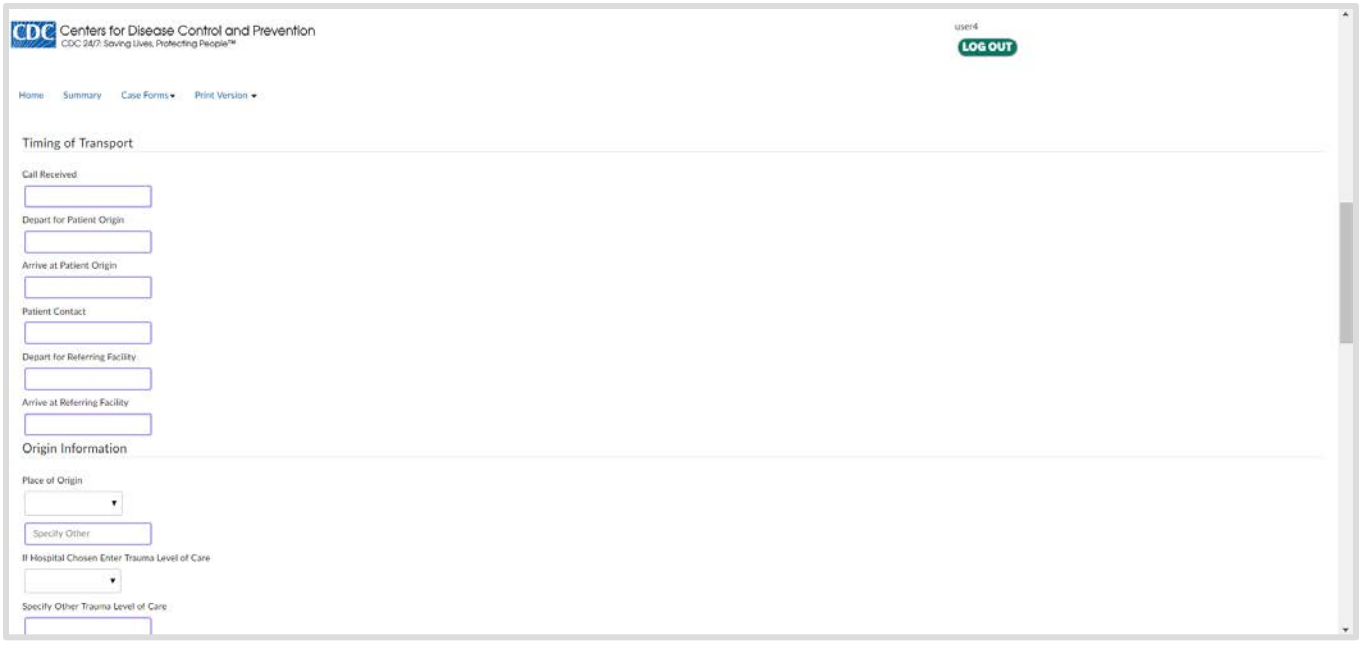

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Census tract certainty code
Census tract certainty name
Urban status
Relevant Medical History Finding
Comment(s)
DELETE
ADD ITEM
Relevant Family History Finding
Comment(s)
DELETE
ADD ITEM
Relevant Social History Finding
Comment(s)
DELETE

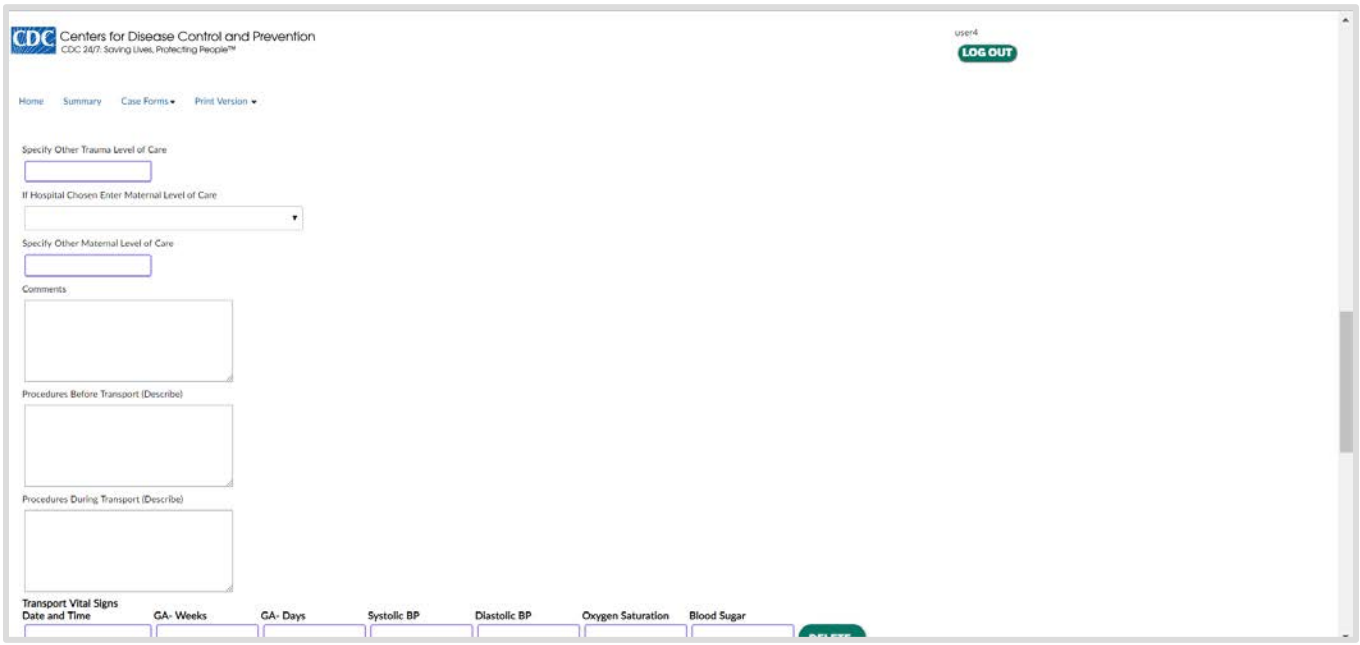

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
ADD ITEM
Referrals and Consultations
Date
Specialty
Reason
Recommendations
DELETE
ADD ITEM
Medications
Date and Time
Medication Name
Dose/Frequency/Duration
Adverse Reaction?
DELETE
ADD ITEM
Visit Summary
Abnormal Findings
Recommendations and Action Plans
DELETE
ADD ITEM
Reviewer's Notes About This Medical Office Visit
UNDO
SAVE

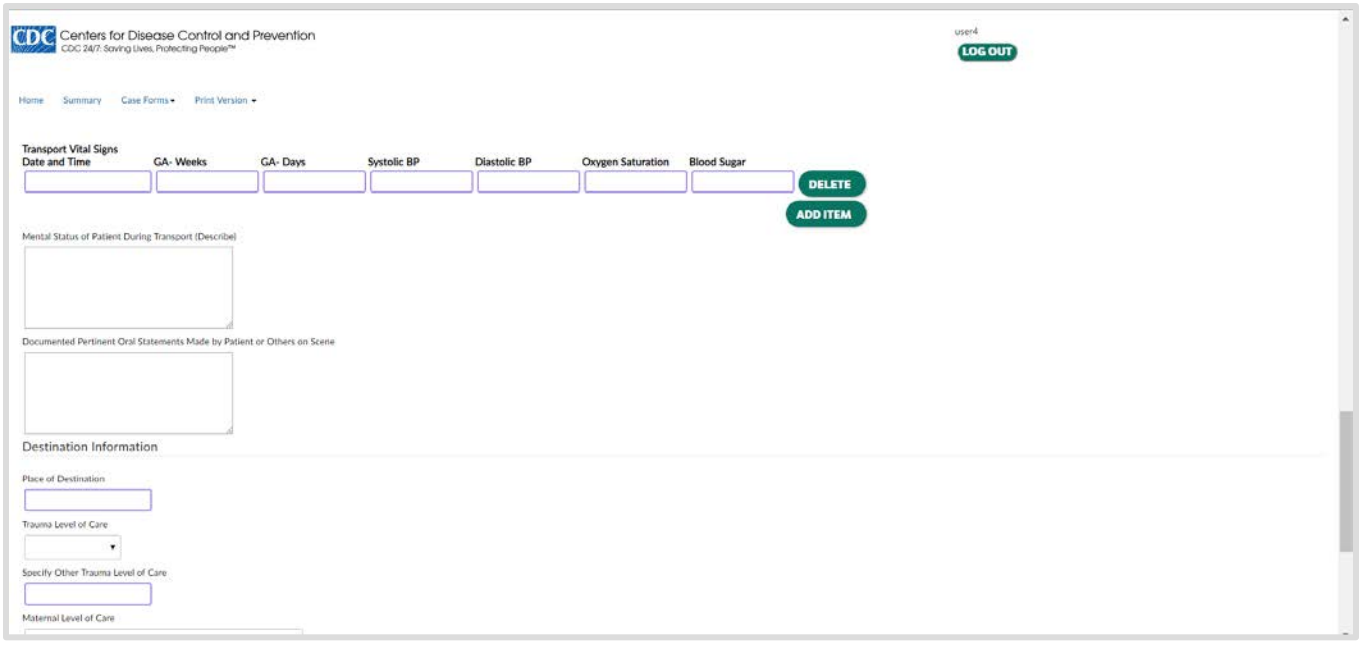
Medical Transport

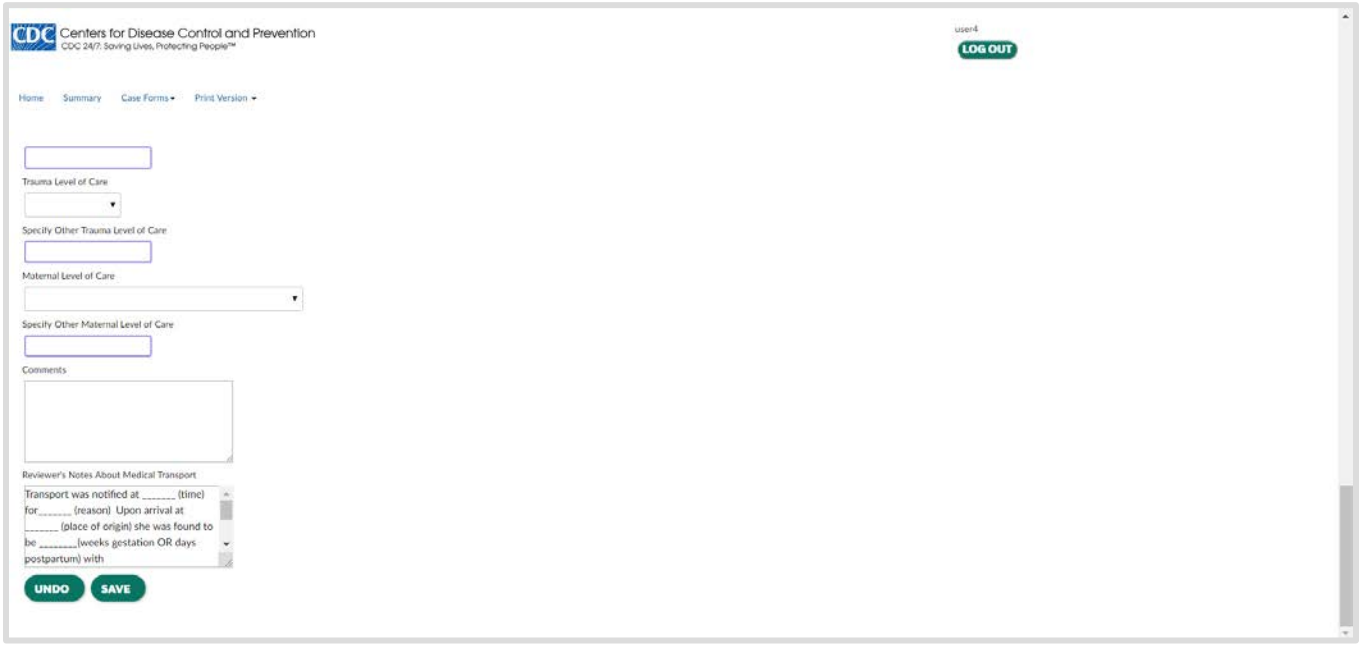




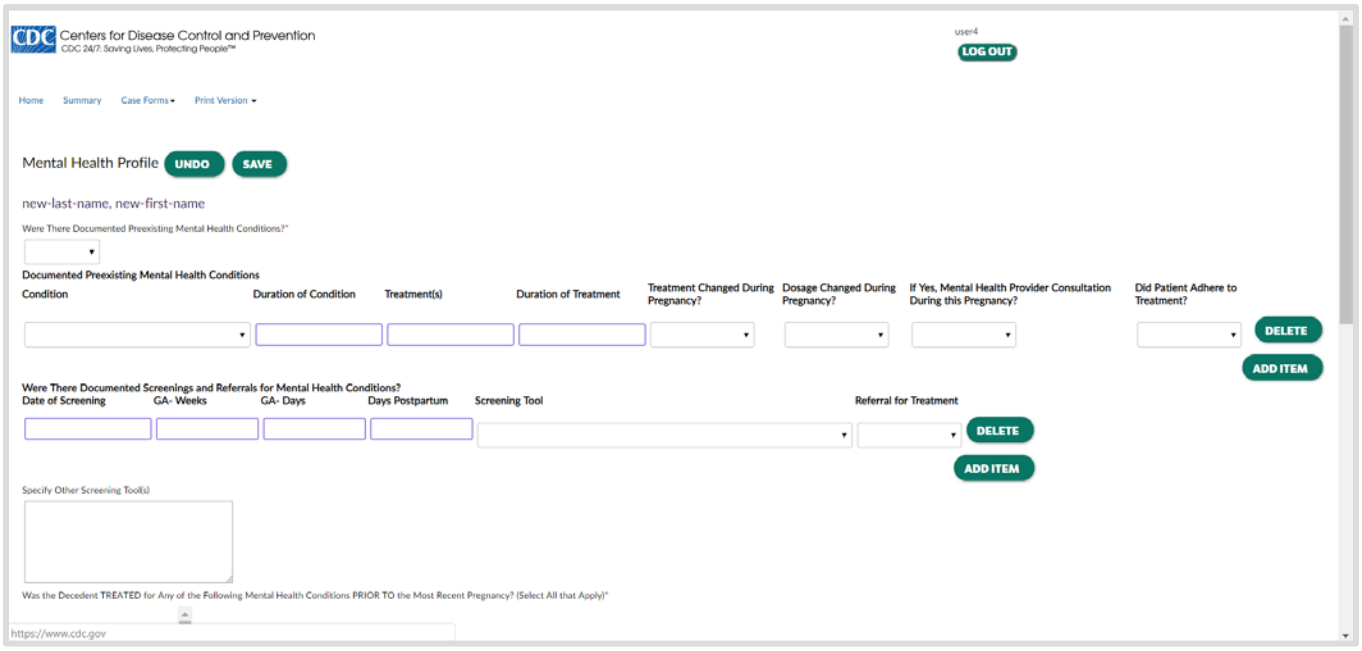

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Timing of Transport
Call Received
Depart for Patient Origin
Arrive at Patient Origin
Patient Contact
Depart for Referring Facility
Arrive at Referring Facility
Origin Information
Place of Origin
Specify Other
If Hospital Chosen Enter Trauma Level of Care
Specify Other Trauma Level of Care

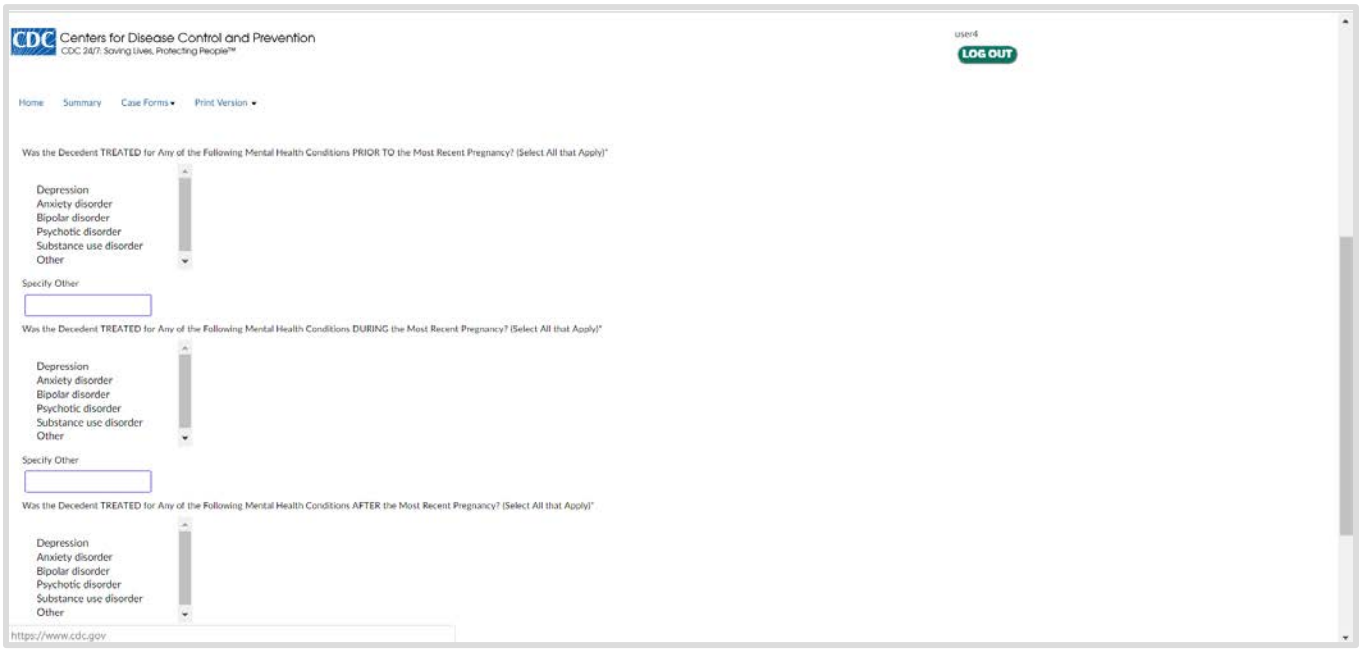

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Specify Other Trauma Level of Care
If Hospital Chosen Enter Maternal Level of Care
Specify Other Maternal Level of Care
Comments
Procedures Before Transport (Describe)
Procedures During Transport (Describe)
Transport Vital Signs
Date and Time
GA- Weeks
GA- Days
Systolic BP
Diastolic BP
Oxygen Saturation
Blood Sugar

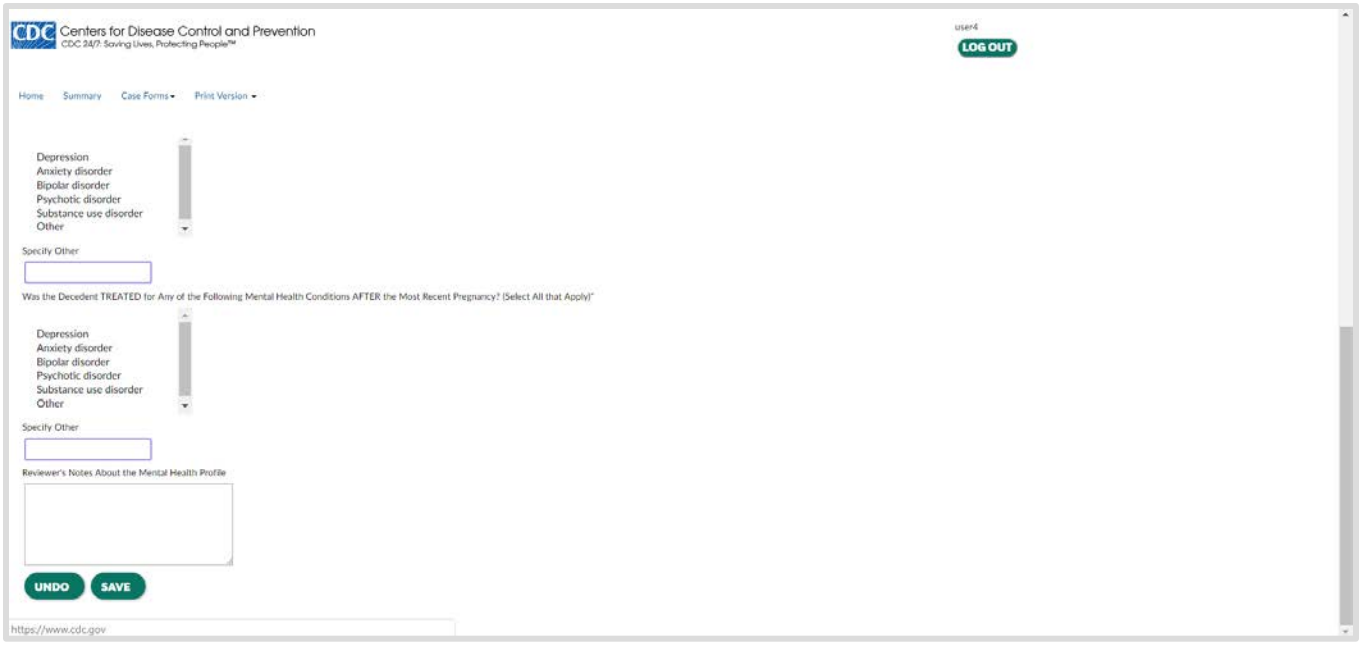

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Transport Vital Signs
Date and Time
GA- Weeks
GA- Days
Systolic BP
Diastolic BP
Oxygen Saturation
Blood Sugar
DELETE
ADD ITEM
Mental Status of Patient During Transport (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


Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
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
UNDO
SAVE

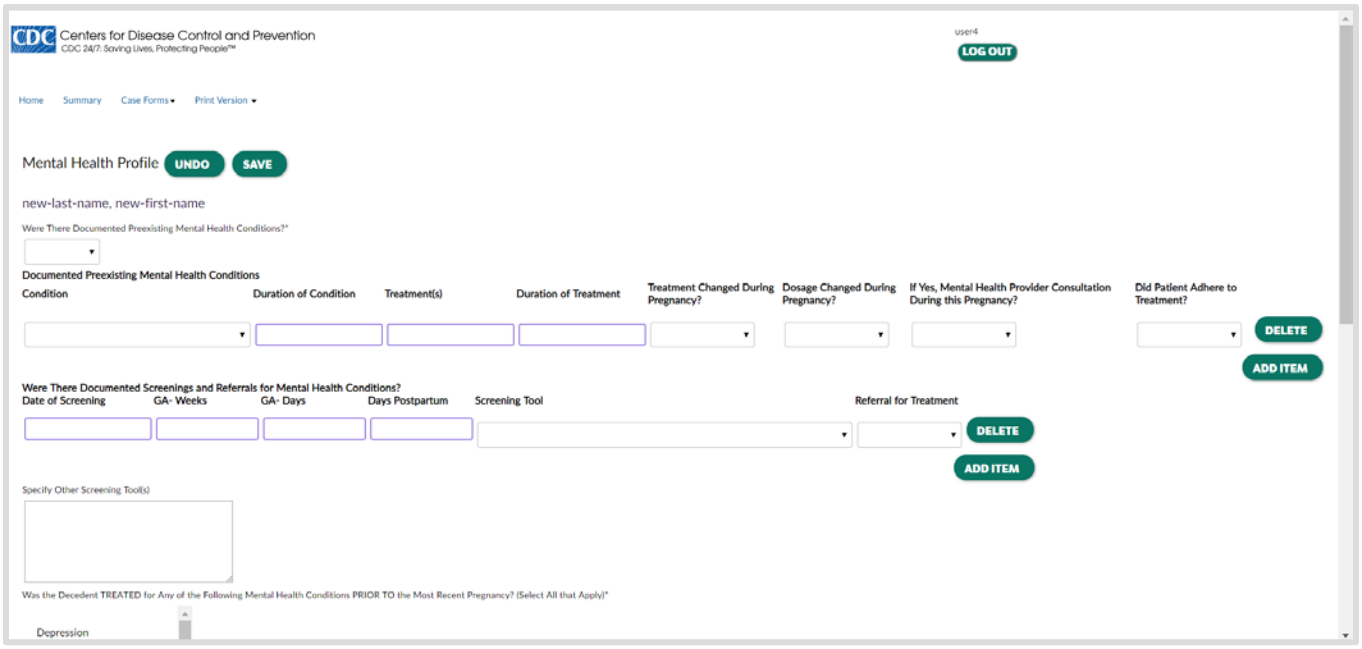
Social and Environmental Profile

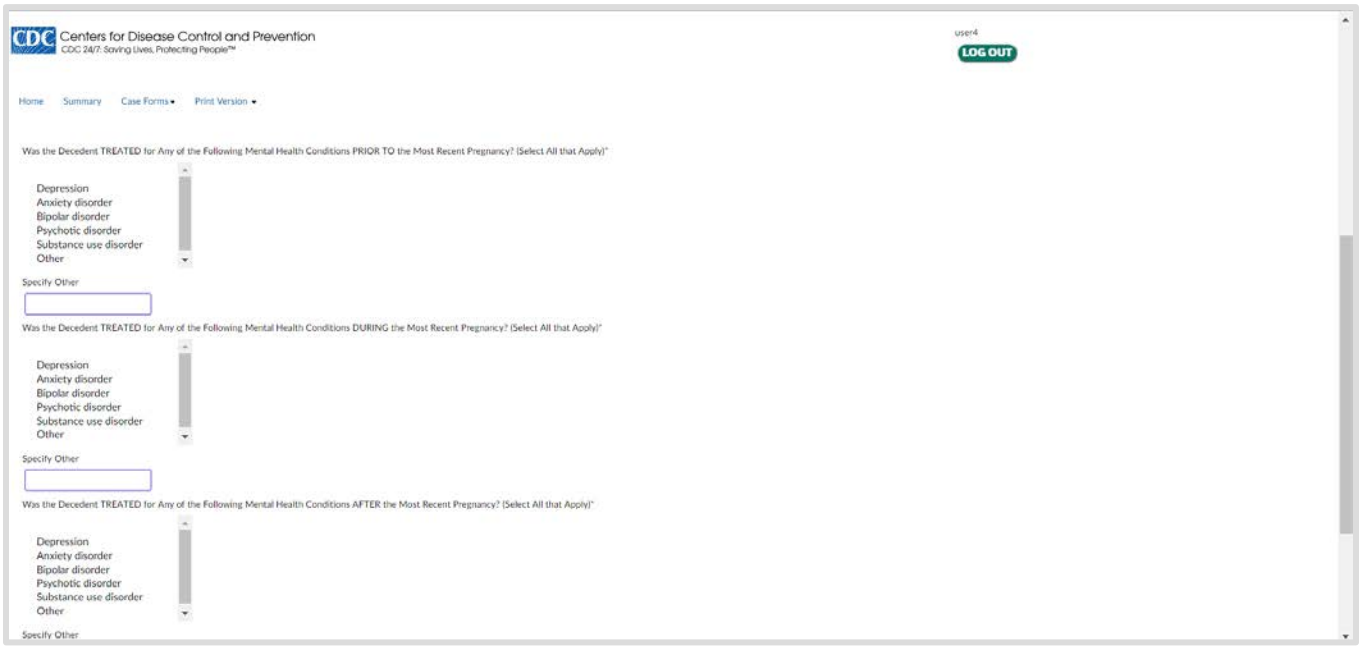


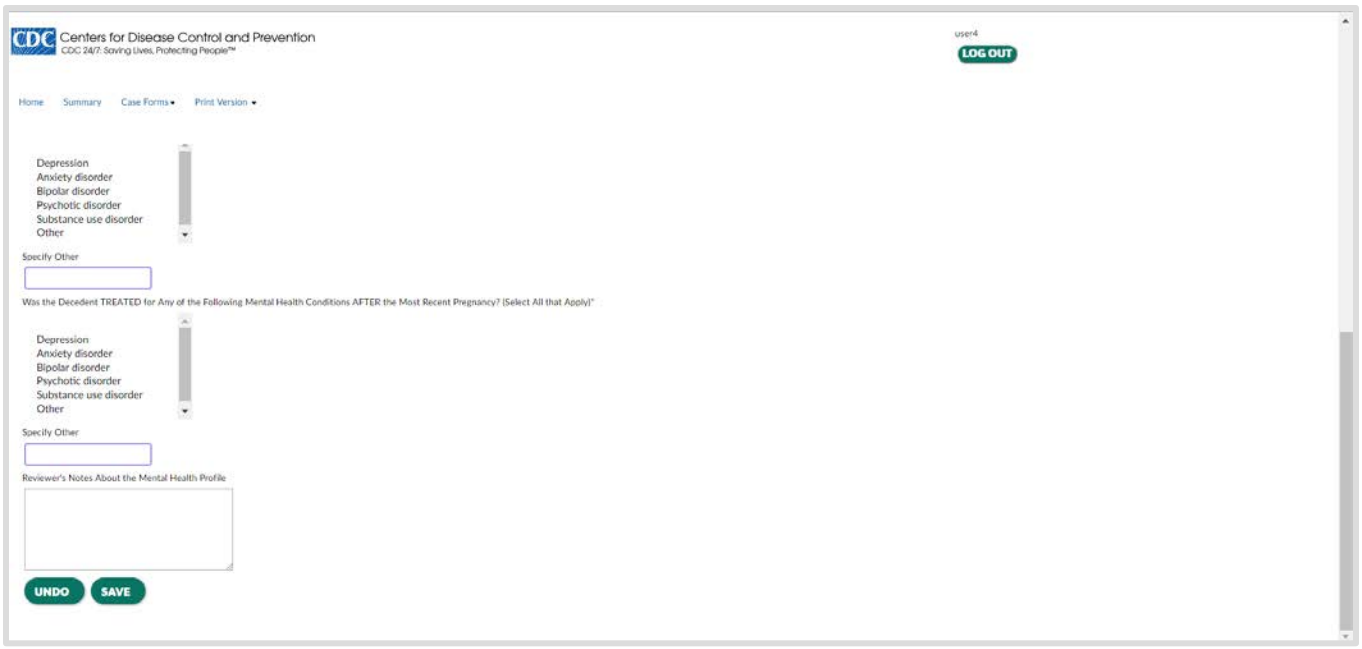



Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
Depression
Anxiety disorder
Bipolar disorder
Psychotic disorder
Substance use disorder
Other
Specify Other
Was the Decedent TREATED for Any of the Following Mental 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
SAVE
https://www.cdc.gov

Mental Health Profile






Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™
user4
LOG OUT
Home
Summary
Case Forms
Print Version
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
SAVE

Informant Interviews