MMRIA Home

Form Approved
OMB No. 0920-1294
Exp. Date 04/30/2023

Abstractor

- View Case Data
- Export Data
- View Overdose Data Summary
- View Aggregate Report
- View Data Quality Report
- View Vitals Import History

Analyst

- View Case Data
- Export Data
- View Overdose Data Summary
- View Aggregate Report
- View Data Quality Report

Committee Member

- View De-identified Case Data

Jurisdiction Admin

- Manage Users & Case Folders
- Manage Case Check Outs
- View Vitals Import History

General

- View Account Profile
- View MMRIA Data Dictionary
- Click here to access the ERASE-MM Community Vital Signs (CVS) Project (external)

Help

- For MMRIA application support, please email MMRIASupport@cdc.gov.
- For MMRIA user roles or permissions, please contact your MMRIA Jurisdiction Administrator.
- For SAMS login support, please email samshelp@cdc.gov or call 877-681-2901.
- Click here to access the ReviewToAction Resource Center (external).
- Click here to access MMRIA system specific documentation and data quality reports.

Role assignment list

Role Name	Case Folder Access	Is Active	Start Date	End Date	Days until Role Expires	Role Added By
committee_member	Top Folder	true	2020-01-27	never	0	user4
abstractor	Top Folder	true	2021-11-16	never	0	sysadmin
jurisdiction_admin	Top Folder	true	2022-08-15	never	0	user5
data_analyst	Top Folder	true	2022-08-15	never	0	sysadmin

22.08.15 v()

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Enable Edit | Save & Continue | Save & Finish

View Audit Log

Select a form to print | View | View PDF | Save PDF

Undo

Case Folder: Top Folder **Record ID:** TEST-2020-5473

Home Record

Reporting state: test
Case Status: Abstracting (Incomplete)
Date created: user9 7/20/2022 05:12:49
Last updated: user9 7/20/2022 15:24:46

First Name: TEST
Middle Name:
Last Name: MMRIA

Date of Death*

Month: 1
Day: 1
Year: 2020

State of Death Record*: Georgia
Record ID*: TEST-2020-5473
Agency-Based Case Identifier:

How was this Death Identified? (Select All That Apply)*

- [ ] Obstetric ICD codes from the Death Certificate
- [ ] Pregnancy Checkbox on Death Certificate
- [ ] Record Linkage of Death and Birth/Fetal Death Certificates
- [ ] Record Linkage of Death Certificate and Hospital Discharge Data
- [ ] Facility Reporting
- [ ] Obituary
- [ ] Social Media
- [ ] Identified by CDC
- [ ] Other
- [ ] Unknown

Specify Other or Additional Sources:

Primary Abstractor:
Case Folder: Top Folder

Overall Case Status

Note: Setting the Case Status to "Review Complete and Decisions Entered", or "Out of Scope and Death Certificate Entered", or "False Positive and Death Certificate Entered", will lock the case and no further updates will be permitted to the case.

Case Status: Abstracting (Incomplete)

Overall Case Status

Abstraction Begin Date: 07/20/2022
Abstraction Complete Date: mm/dd/yyyy

Projected Review Date mm/dd/yyyy

Committee Review Date mm/dd/yyyy

Case Locked Date

Overall Assessment of the Timing of Death and Pregnancy Outcome

Please fill out the field(s) below once you have completed abstraction of the case. Your responses represent your Overall Assessment of the Timing of Death in relation to pregnancy and are not based upon any particular source record.

Abstractor-assigned pregnancy status based on overall review of records

Pregnant within 42 days of death

# of days after end of pregnancy (Count first 24 hours after end of pregnancy as 0. If the death occurred during pregnancy, this field should be left blank.)

Pregnancy Outcome

Other

Specify Other Pregnancy Outcome

Form Status

Death Certificate

(Select Value)

Autopsy Report

(Select Value)

Birth/Fetal Death Certificate- Parent Section

(Select Value)

Birth/Fetal Death Certificate- Infant/Fetal Section

(Select Value)

Community Vital Signs

(Select Value)

Social and Environmental Profile

(Select Value)

Prenatal Care Record

(Select Value)

ER Visits and Hospitalizations

(Select Value)

Other Medical Office Visits

(Select Value)

Medical Transport

(Select Value)

Mental Health Profile

(Select Value)

Informant Interviews

(Select Value)

Case Narrative

(Select Value)

Committee Decisions

(Select Value)

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Enable Edit | Save & Continue | Save & Finish

View Audit Log

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Undo

Case Folder: Top Folder **Record ID:** TEST-2020-5473

Death Certificate

Reporting state: test

Case Status: Abstracting (Incomplete)

Date created: user9 7/20/2022 05:12:49

Last updated: user9 7/20/2022 10:11:08

Maternal Death Certificate Identification

Time of Death | Local File Number | State File Number

Place of Last Residence

Street | Apartment or Unit Number

City | State* | Country*

(Select Value) | (Select Value)

Zip Code | County

Validate Address and Get Geography Context | Clear | View Community Vitals Signs PDF

Matching Geography Type | Census Tract Certainty Code | Census Tract Certainty Name | Urban Status

Latitude | Longitude

Demographics

Date of Birth*

Month | Day | Year

(Select | (Select | (Select

Age at Death (calculated)* | Age at Death (on death certificate)

Marital Status* | City of Birth

(Select Value)

State of Birth | Country of Birth (If Foreign Born)* | Primary Occupation*

(Select Value) | (Select Value)

Business/Industry | Ever in U.S. Armed Forces?

(Select Value)

Hispanic Origin?* | Other Hispanic, Specify

(Select Value)

Education*

(Select Value)

Citizen of What Country (Select Value)

Race

Race*

- [ ] White
- [ ] Black or African American
- [ ] American Indian or 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

OMB Race Recode

(Select Value)

Injury Associated Information

Date of Injury

Month (Selec) Day (Selec) Year (Selec)

Time of Injury

Place of Injury (Place Name, if Applicable)

Was Injury at Work? (Select Val)

Transportation Related Injury? (Select Value)

Specify Other

Were Seatbelts in Use? (Select Value)

Location Where Injury Occurred

Street

Apartment or Unit Number

City | State | Zip Code | County

(Select Value)

Validate Address and Get Geography Context | Clear

Matching Geography Type | Census Tract Certainty Code | Census Tract Certainty Name | Urban Status

Death Information

If Death Occurred in Hospital* | If Death Not in a Hospital* | Specify Other

(Select Value) | (Select Value)

Manner of Death* | Was Autopsy Performed?* | Were autopsy findings available to complete the cause of death?*

(Select Value) | (Select Value) | (Select Value)

Pregnancy Status* | Did Tobacco Contribute to Death?

(Select Value) | (Select Value)

Location Where Death Occurred

Place of Death (Facility Name, if Applicable)

Street | Apartment or Unit Number

City | State* | Zip Code | County

(Select Value)

Validate Address and Get Geography Context | Clear

Matching Geography Type | Census Tract Certainty Code | Census Tract Certainty Name | Urban status

Estimated Distance (Miles) Between Residence and Place of Death*

Calculate Distance | Clear

Causes of Death - 1 item(s)

item 1 of 1

Type* | Cause (Descriptive)*

(Select Value)

ICD Code | Interval | Unit

(Select Value)

+Add Item

Reviewer's Notes about the Death Certificate

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Enable Edit | Save & Continue | Save & Finish

View Audit Log

Select a form to print | View | View PDF | Save PDF

Undo

Case Folder: Top Folder **Record ID:** TEST-2020-5473
Birth/Fetal Death Certificate- Parent Section
Reporting state: test
Case Status: Abstracting (Incomplete)
Date created: user9 7/20/2022 05:12:49
Last updated: user9 7/20/2022 15:04:06

Facility of Delivery Demographics

Date of Delivery

Month (Select) | Day (Selec) | Year* (Selec)

Place where Birth Occurred* (Select Value)

Planned to Deliver at Home? (Select Value)

Maternal Level of Care* (Select Value)

Specify Other Maternal Level of Care

Facility NPI Number

Facility Name

Attendant's Title* (Select Value)

Specify Other Title

Attendant's NPI

Was Mother Transferred?* (Select Value)

If Yes, Enter Name of Facility Mother Transferred From

Facility of Delivery Location

Street

Apartment or Unit Number

City

State* (Select Value)

Zip Code

County

Validate Address and Get Geography Context | Clear

Matching Geography Type

Census Tract Certainty Code

Census Tract Certainty Name

Urban Status

Father's Demographics

Date of Birth

Month (Select) | Year (Selec) | Age

Father's Education

(Select Value)

Father's City of Birth | Father's State of Birth | Father's Country of Birth (if Foreign Born)

(Select Value) | (Select Value)

Father's Primary Occupation | Business/Industry | Father of Hispanic Origin?

(Select Value)

Other Hispanic, Specify

Father's Race

Father's Race (Select All That Apply)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or 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

Father's OMB Race Recode

(Select Value)

Maternal Record Identification

First Name | Middle Name | Last Name | Maiden Name

Medical Record Number

Mother's Demographics

Date of Birth

Month | Day | Year | Age*

(Selec) (Selec) (Selec)

Mother Married?* If No, has Paternity Acknowledgement been Signed in the Hospital?

(Select Val) (Select Val)

Mother's City of Birth | Mother's State of Birth (US) | Mother's Country of Birth (if Foreign Born)*

(Select Value) (Select Value)

Primary Occupation | Business/Industry | Ever in U.S. Armed Forces?

(Select Val)

Mother of Hispanic Origin?*

(Select Value)

Other Hispanic, Specify

Education*

(Select Value)

Location of Residence

Street | Apartment or Unit Number

City | State* | Zip Code | County

(Select Value)

Validate Address and Get Geography Context | Clear

Matching Geography Type | Census Tract Certainty Code | Census Tract Certainty Name | Urban Status

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

Calculated Distance | Clear

Mother's Race

Mother's Race (Select All That Apply)*

- [ ] White
- [ ] Black or African American
- [ ] American Indian or Alaska Native
- [ ] Native Hawaiian
- [ ] Guamanian or Chamorro
- [ ] Samoan
- [ ] Other Pacific Islander
- [ ] Asian Indian

- [ ] Asian Indian
- [ ] Chinese
- [ ] Filipino
- [ ] Japanese
- [ ] Korean
- [ ] Vietnamese
- [ ] Other Asian
- [ ] Other Race
- [ ] Race Not Specified

Mother's OMB Race Recode

(Select Value)

Pregnancy History

Date of Last Live Birth

Month (Select) Day (Selec) Year (Select)

Live Birth Interval (Months)

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

Now Living (Do Not Include this Child)

Now Dead

Number of Other Pregnancy Outcomes*

Date of Last Other Pregnancy Outcome

Month (Select) Day (Select) Year (Selec)

Pregnancy Interval (Months)

Maternal Biometrics

Height (Feet)

Height (Inches)

Pre-Pregnancy Weight (lbs)

Weight at Delivery (lbs)

Weight Gain during Pregnancy (lbs)

Pre-Pregnancy BMI*

Prenatal Care

Date Last Normal Menses Began

Month (Select) Day (Select) Year (Select)

Date of First Prenatal Care Visit

Month (Selec) Day (Selec) Year (Selec)

Date of Last Prenatal Care Visit

Month (Select) Day (Select) Year (Select)

Obstetric Estimate of Gestation at Birth (Completed Weeks)*

Calculated Gestation at Birth - Weeks

Calculated Gestation at Birth - Days

Plurality* (Select Value)

Specify, if > 3

Did Mother Get WIC Food for Herself During this Pregnancy?* (Select Value)

Principal Source of Payment for this Delivery* (Select Value)

Specify Other

Trimester of First Prenatal Care Visit* (Select Value)

Total Number of Prenatal Visits for this Pregnancy

Cigarette Smoking Before and During Pregnancy

Three Months Before Pregnancy (# of Cigarettes/Packs)

Unit(s) (Select Value)

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

Unit(s) (Select Value)

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

Unit(s) (Select Value)

Third Trimester of Pregnancy (# of Cigarettes/Packs)

Unit(s) (Select Value)

None or Not Specified (Select Value)

Maternal Risk Factors

Risk Factors in this Pregnancy (Select All That Apply)*

- [ ] 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 the Above

- [ ] Unknown

Number of Previous Cesarean Deliveries

Infections Present or Treated During this Pregnancy (Select All That Apply)*

- [ ] Gonorrhea
- [ ] Syphilis
- [ ] Chlamydia
- [ ] Herpes Simplex [HSV]
- [ ] Hepatitis B (live birth only)
- [ ] Hepatitis C (live birth only)
- [ ] Cytomegalovirus (fetal death only)
- [ ] Genital Herpes (fetal death only)
- [ ] Group B Streptococcus (fetal death only)
- [ ] HIV (fetal death only)
- [ ] Listeria (fetal death only)
- [ ] Parvovirus (fetal death only)
- [ ] Toxoplasmosis (fetal death only)
- [ ] Other
- [ ] None of the Above
- [ ] Unknown

Onset of Labor (Select All That Apply)*

- [ ] Premature Rupture of Membranes (Prolonged)
- [ ] Prolonged Labor (> 20 hours)
- [ ] Precipitous Labor (< 3 hours)
- [ ] None of the Above
- [ ] Unknown

Obstetric Procedures (Select All That Apply)*

- [ ] Cervical Cerclage
- [ ] Tocolysis
- [ ] External Cephalic Version: Successful
- [ ] External Cephalic Version: Failed
- [ ] None of the Above
- [ ] Unknown

Specify Other Infection

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 the above
- [ ] Unknown

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 the above
- [ ] Unknown

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

Calculate Length of Time | Clear

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

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Enable Edit | Save & Continue | Save & Finish

View Audit Log

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Undo

Case Folder: Top Folder **Record ID:** TEST-2020-5473

Birth/Fetal Death Certificate- Infant/Fetal Section (Record 1)

Reporting state: test

Date created: user9 7/20/2022 05:12:49

Last updated: user9 7/20/2022 15:11:46

Back to List of Records

Record Type*

(Select Value)

Multiple Gestation

(Select Value)

Birth Order

Newborn (Fetus) Record Identification

State File Number

Local File Number

Newborn Medical Record Number

Date of Delivery

mm/dd/yyyy

Time of Delivery

Newborn (Fetus) Biometrics and Demographics

Birth Weight

Unit of Measurement

(Select Value)

Value (Grams or Pounds)*

Value (Ounces)*

Gender

(Select Value)

Apgar Scores

5 Minute

10 Minute

Is Infant Living at Time of Report?

(Select Value)

Is Infant Being Breastfed at Discharge?

(Select Value)

Was Infant Transferred Within 24 Hours of Delivery?

(Select Value)

Specify Facility, City, and State

Method of Delivery

A. Was Delivery With Forceps Attempted but Unsuccessful?

(Select Value)

B. Was Delivery With Vacuum Extraction Attempted but Unsuccessful?

(Select Value)

C. Fetal Presentation at Birth

(Select Value)

Specify Other Presentation

D. Final Route and Method of Delivery*

(Select Value)

If Cesarean, was a Trial of Labor Attempted?

(Select Value)

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
- ☐ Unknown

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
- ☐ Unknown

ICD Version

Causes of Fetal Death - 1 item(s)

item 1 of 1

Type	Class	Complication Subclass

Other (Specify)	ICD Code

+Add Item

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

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Enable Edit | Save & Continue | Save & Finish

View Audit Log

Select a form to print | View | View PDF | Save PDF

Undo

Case Folder: Top Folder **Record ID:** TEST-2020-5473

Community Vital Signs

Reporting state: test
Case Status: Abstracting (Incomplete)
Date created: user9 7/20/2022 05:12:49
Last updated: user5 8/15/2022 14:15:50

View Community Vital Signs PDF

Was Community Vital Signs used in case review? (Select Value)

If Yes, how was Community Vital Signs used?

(Select Value)

If Yes, how was Community Vital Signs used, specify other

Reviewer's Notes about the Community Vital Signs

She (or use pseudonym) lived in a community that was characterized as being “lower than average” for (insert domains). The community was characterized as being “average” for (insert domains) and “higher than average” for (insert domains).

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View Audit Log

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Undo

Case Folder: Top Folder **Record ID:** TEST-2020-5473

Social and Environmental Profile

Reporting state: test

Case Status: Abstracting (Incomplete)

Date created: user9 7/20/2022 05:12:49

Last updated: user9 7/20/2022 10:24:28

Socioeconomic Characteristics

Source of Income

(Select Value)

Specify Multiple/Other Sources of Income

Employment Status

(Select Value)

Specify Multiple/Other Employment Status

Occupation

Religious Preference

Country of Birth

(Select Value)

Immigration Status

(Select Value)

Time in the US

Units

(Select

Living Arrangement at Time of Death

(Select Value)

Homelessness*

- ☐ Never
- ☐ More than 1 Year Prior to Pregnancy
- ☐ Within 1 Year Prior to Pregnancy
- ☐ During Pregnancy
- ☐ After Pregnancy
- ☐ Unknown
- ☐ Yes, in Last 12 Months (Obsolete)
- ☐ Yes, but More than 12 Months Ago (Obsolete)

Unstable Housing?

- ☐ Never
- ☐ More than 1 Year Prior to Pregnancy
- ☐ Within 1 Year Prior to Pregnancy
- ☐ During Pregnancy
- ☐ After Pregnancy
- ☐ Unknown

Gender Identity

The purpose of the following question is not to *determine* an individual's gender identity, but to document a decedent's gender identity as recorded on any information available including the decedent's social media and any informant interviews.

Was the decedent's gender identified as not female* in any of the records available to the abstractor(s)?

(Select Value)

*Examples of gender terms that indicate the decedent's gender was identified as not female: male, transgender, gender neutral, non-binary, agender, pangender, genderqueer, two-spirit, third gender.

Please identify the source(s) of information from which the decedent's gender was identified as not female*.

- ☐ Death Record

- [ ] Infant birth or fetal death record
- [ ] Autopsy report
- [ ] Prenatal care record
- [ ] Emergency Department visit or hospitalization record
- [ ] Other medical record
- [ ] Medical transport record
- [ ] Informant interview
- [ ] Social media
- [ ] Other

Describe Other source(s)

Please enter the term(s) used in the source documents that identified the decedent's gender as not female*.

Members of Household - 1 item(s)

item 1 of 1

Relationship	Gender	Age
(Select Value)	(Select Value)	

Comments

+Add Item

Was Decedent Ever Incarcerated?

- [ ] Never
- [ ] More than 1 Year Prior to Pregnancy
- [ ] Within 1 Year Prior to Pregnancy
- [ ] During Pregnancy
- [ ] After Pregnancy
- [ ] Unknown
- [ ] Before Pregnancy (Obsolete)

Details of Incarcerations - 1 item(s)

item 1 of 1

Date	Duration	Reason

mm/dd/yyyy

Occurrence

(Select Value)

Comments

+Add Item

Was Decedent Ever Arrested?

- [ ] Never
- [ ] More than 1 Year Prior to Pregnancy
- [ ] Within 1 Year Prior to Pregnancy
- [ ] During Pregnancy
- [ ] After Pregnancy
- [ ] Unknown

Details of Arrests - 1 item(s)

item 1 of 1

Date

mm/dd/yyyy

Reason

Occurrence

(Select Value)

Comment(s)

+Add Item

Health Care Access

Documented Barriers to Health Care Access* (Select All That Apply)

- [ ] Child Care
- [ ] Cultural Norms
- [ ] Distance
- [ ] Financial
- [ ] Mobility

- [ ] Transportation
- [ ] Other
- [ ] None
- [ ] Unknown

Specify Other Barrier to Health Care Access

Comments

Communications

Documented Barriers to Communications* (Select All That Apply)

- [ ] Cultural Differences
- [ ] Functional Illiteracy
- [ ] Hearing Impaired
- [ ] Language Differences
- [ ] Speech Impaired
- [ ] Vision Impaired
- [ ] Other
- [ ] None
- [ ] Unknown

Specify Other Barrier to Communications

Comments

Social or Emotional Stress

Evidence of Social or Emotional Stress* (Select All That Apply)

- ☐ History of Domestic Violence
- ☐ History of Psychiatric Hospitalizations or Treatment
- ☐ Child Protective Services Involvement
- ☐ History of Substance Use
- ☐ Unemployment
- ☐ History of Treatment for Substance Use
- ☐ Pregnancy Unwanted
- ☐ Recent Trauma
- ☐ History of Childhood Trauma
- ☐ Prior Suicide Attempts
- ☐ Other
- ☐ None
- ☐ Unknown

Specify Other Evidence of Stress

Explain Further

Comments

Military Status at Time of Death

(Select Value)

Is There Documentation of Bereavement Support?

(Select Value)

Social and Medical Referrals - 1 item(s)

✕ item 1 of 1

Date	Referred To	Specialty
mm/dd/yyyy		

Reason

Adhered?

(Select Val

Reason for Non-Adherence

Comment(s)

+Add Item

Sources of Social Services Information for this Record - 1 item(s)

item 1 of 1

Date

mm/dd/yyyy

Element

(Select Value)

Specify Other Element

Source Name

Comment(s)

+Add Item

Was There Documented Substance Use?*

(Select Valu

If Yes, Specify Substance(s) - 1 item(s)

item 1 of 1

Documented Substance

(Select Value)

Timing of Substance Use

(Select Value)

+Add Item

Reviewer's Notes About the Social and Environmental Profile

She (or use pseudonym) had the following barriers to accessing healthcare _____ (or state no barriers to accessing healthcare) and had missed appointments due to _____. She had the following barriers to communication (or state no barriers to communication). She had (stable or unstable) housing. Evidence of social or emotional stress included (add factors noted on the Social and Environmental form, including any history of arrest or incarceration, or state no evidence of).

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Enable Edit | Save & Continue | Save & Finish

View Audit Log

Select a form to print | View | View PDF | Save PDF

Case Folder: Top Folder **Record ID:** TEST-2020-5473

Autopsy Report

Undo

Reporting state: test
Case Status: Abstracting (Incomplete)
Date created: user9 7/20/2022 05:12:49
Last updated: user9 7/20/2022 10:42:58

Was there an Autopsy Referral?
(Select Value)

What Type of Autopsy or Examination was Performed?
(Select Value)

Is Autopsy/External Examination Report Available?
(Select Vali

Was Toxicology Performed?
(Select Vali

Is Toxicology Report Available?
(Select Value)

Completeness of Autopsy Information*
(Select Value)

Reporter Characteristics

Reporter Type
(Select Value)

Specify Other Reporter Type

Date of Autopsy

Month
(Select

Day
(Selec

Year
(Selec

Jurisdiction

Biometrics

Maternal

Height

Feet

Inches

Weight (lbs)

BMI*

Fetus (If Applicable)

Weight: Unit of Measurement
(Select Value)

Weight: Value (Grams or Pounds)

Weight: Value (Ounces)

Length: Unit of Measurement

Length: Value (Inches or Cm)

(Select Value)

Estimate of Gestational Age (Weeks)

Findings Relevant to Maternal Death

Gross Findings - 1 item(s)

item 1 of 1

Finding

Comment(s)

+Add Item

Microscopic Findings - 1 item(s)

item 1 of 1

Finding

Comment(s)

+Add Item

Was Toxicology Positive for Drugs?* (Select Value)

Toxicology* - 1 item(s)

item 1 of 1

Substance	Concentration	Unit of Measure	Level
(Select Value)			(Select Valu

Comment(s)

+Add Item

ICD Code Version

Coroner/Medical Examiner Causes of Death - 1 item(s)

item 1 of 1

Type	Cause	ICD Code	Comment(s)
(Select Value)			

+Add Item

Reviewer's Notes About the Autopsy Report

She (or use pseudonym) presented to _____ (describe location if applicable) at _____ (describe weeks gestation or postpartum status). (Briefly provide synopsis of events that led to the death): She died at (insert weeks gestation or days/weeks/months postpartum) due to (natural/accidental/violent) causes with an underlying cause of death listed on the death certificate as (insert cause listed on death certificate). Her death (was/was not) referred for autopsy. Autopsy was done by a _____ (OR was not done). Systems Exam (Gross Findings) included _____, Microscopic Exam: _____, Toxicology Results: _____Cause of Death (per autopsy): _____.

(Describe if any bereavement services were documented.) _____.

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Enable Edit | Save & Continue | Save & Finish

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Undo

Case Folder: Top Folder **Record ID:** TEST-2020-5473

Prenatal Care Record

Reporting state: test
Case Status: Abstracting (Incomplete)
Date created: user9 7/20/2022 05:12:49
Last updated: user9 7/20/2022 10:44:23

Prenatal Care Record Number

Was There More than One Prenatal Care Source?

(Select Value)

Primary Prenatal Care Facility

Place Type

(Select Value)

Specify Other Place Type

Primary Provider Type

(Select Value)

Specify Other Provider Type

Principal Source of Payment*

(Select Value)

Specify Other

Use of WIC*

(Select Value)

Location of Primary Prenatal Care Facility

Street

Apartment or Unit Number

City

State*

(Select Value)

Zip Code

County

Validate Address and Get Geography Context | Clear

Matching Geography Type

Census Tract Certainty Code

Census Tract Certainty Name

Urban Status

Prior Surgical Procedures Before this Pregnancy - 0 item(s)

+Add Item

Were There Documented Preexisting Medical Conditions?*

(Select Value)

Pre-existing Conditions - 1 item(s)

item 1 of 1

Condition | Other (Specify) | Duration

(Select Value)

Comment(s)

+Add Item

Were There Documented Mental Health Conditions?* (Select Value)

Family Medical History - 1 item(s)

item 1 of 1

Relation | Condition | Living? | Age at Death

(Select Va | (Select Val

Comment(s)

+Add Item

Was There Evidence of Substance Use? (Select Value)

Evidence of Substance Use - 1 item(s)

item 1 of 1

Substance | Screening | Counseling/Education

(Select Value) | (Select Value) | (Select Value)

Comment(s)

+Add Item

Pregnancy Details

Gravida* (include current pregnancy) | Para* | Abortions*

Pregnancy History Details - 1 item(s)

item 1 of 1

Date Ended | Outcome | Gestational Age - Weeks

mm/dd/yyyy | (Select Value)

Birth Weight: Unit of Measurement | Birth Weight (Grams or Pounds) | Birth Weight (Ounces)

(Select Value)

Method of Delivery | Complication(s) | Now Living?

(Select Value)

+Add Item

Intendedness (Sentinel Pregnancy)

Date Birth Control was Discontinued

Month (Selec) | Day (Selec) | Year (Selec)

Was Pregnancy Planned?

(Select Value)

Specify Other

Was Patient Using Birth Control?

(Select Valu)

Specify Other Birth Control Method

Infertility Treatment (Sentinel Pregnancy)

Did this Pregnancy Result from Infertility Treatment?*

(Select Value)

Fertility Enhancing Drugs

(Select Val)

Assisted Reproductive Technology (ART)

(Select Val)

ART Type

(Select Value)

Specify Other ART Type

Cycle Number

Embryos Transferred

Embryos Growing

Sentinel Pregnancy

Date of Last Normal Menses*

Month (Selec) | Day (Selec) | Year (Selec)

Estimated Date of Delivery

Month (Selec) | Day (Selec) | Year (Selec) | Estimate Based on (Select Value)

Date of First Prenatal Visit*

Month (Selec) | Day (Selec) | Year (Selec)

Gestational Age at First Prenatal Visit - Weeks

Gestational Age at First Prenatal Visit - Days

Date of First Ultrasound

Month (Selec) | Day (Selec) | Year (Selec)

Gestational Age Reported at First Ultrasound - Weeks

Gestational Age Reported at First Ultrasound - Days

Date of Last Prenatal Visit | Height*

Date of Last Prenatal Visit

Month (Selec) Day (Selec) Year (Selec)

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* | Trimester of First Prenatal Care Visit* (Select Value) | Number of Fetuses

Was Home Delivery Planned? (Select Value) | Attended Prenatal Care Visits Alone?* (Select Value) | Name, City, and State of Intended Birthing Facility

Routine Monitoring - 1 item(s)

item 1 of 1

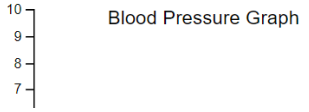
Date (mm/dd/yyyy) | GA - Weeks | GA - Days | Systolic BP

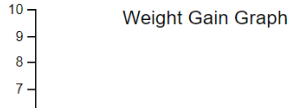
Diastolic BP | Heart Rate | Oxygen Saturation

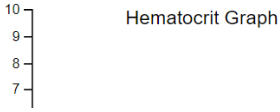
Urine Protein (Select) | Urine Ketones (Select) | Urine Glucose (Select) | Blood Hematocrit (%) | Weight (lbs)

Comment(s)

+Add Item







Highest Blood Pressure*

Systolic BP

Diastolic BP

Lowest Hematocrit*

Other Laboratory Tests - 1 item(s)

item 1 of 1

Date

mm/dd/yyyy

GA - Weeks

GA - Days

Test/Procedure

Results (units)

Comment(s)

+Add Item

Diagnostic Procedures - 1 item(s)

item 1 of 1

Date

mm/dd/yyyy

GA - Weeks

GA - Days

Procedure

Comment(s)

+Add Item

Were there Problems Identified During the Sentinel Pregnancy?*

(Select Value)

Problems Identified During the Sentinel Pregnancy - 1 item(s)

item 1 of 1

Date First Noted

mm/dd/yyyy

GA - Weeks

GA - Days

Problem

Comment(s)

+Add Item

Were There Any Adverse Reactions?*

(Select Val

Prescribed Medications/Drugs - 1 item(s)

item 1 of 1

Date | GA - Weeks | GA - Days | Medication

mm/dd/yyyy

Dose / Frequency / Duration | Reason | Adverse Reactions?*

(Select Value)

+Add Item

Were There Pre-Delivery Hospitalizations or ER Visits?*

(Select Value)

Pre-Delivery Hospitalization Details - 1 item(s)

item 1 of 1

Date | GA - Weeks | GA - Days | Facility

mm/dd/yyyy

Duration | Reason

Comment(s)

+Add Item

Were There Referrals to Other Medical Specialists/Subspecialties?*

(Select Value)

Medical Referral Details - 1 item(s)

item 1 of 1

Date | GA - Weeks | GA - Days | Type of Specialist

mm/dd/yyyy

Reason | Appointment Kept?

(Select Value)

+Add Item

Sources of Prenatal Care Information, Other than the Primary Provider (Transferred Records) - 1 item(s)

item 1 of 1

Place	Provider Type	City	State
(Select Value)	(Select Value)		(Select Value)

Begin Date	End Date
mm/dd/yyyy	mm/dd/yyyy

Comment(s)

+Add Item

Reviewer's Notes About the Prenatal Care Records

For this current pregnancy she entered prenatal care at_____ weeks with _____# visits at a ___ (describe location: clinic, office, etc.) with a _____ (provider type). She had (private, public, or no insurance during prenatal care). Her pre-pregnancy body mass index (BMI) was ____ with a height of ____ and weight of _____. Her pregnancy history included ___# full-term, _____# preterm, _____# abortion/miscarriage and _____# of living children (not including the sentinel pregnancy). Her current pregnancy was known to have (insert complications during pregnancy- include identified obstetric risk factors or other medical conditions including mental health and treatments) which impacted this pregnancy. Her family medical history was significant for _____. Referrals during prenatal period were to _____ (provider type) at _____ weeks gestation for _____ (describe reason).

(Insert any additional key prenatal visit details as applicable including barriers to accessing care or noted reasons for missed appointments.)

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Undo

Case Folder: Top Folder **Record ID:** TEST-2020-5473

ER Visits and Hospitalizations (Record 1)

Reporting state: test

Date created: user9 7/20/2022 05:12:49

Last updated: user9 7/20/2022 15:14:26

> Back to List of Records

Maternal Record Identification

Medical Record Number

Basic Admission and Discharge Information

Date of Arrival at Hospital/ER

Month (Selec) Day (Selec) Year (Selec)

Time of Arrival

Gestational Age - Weeks

Gestational Age - Days

Days Postpartum

Date of Admission to Hospital

Month (Selec) Day (Selec) Year (Selec)

Time of Admission

Gestational Age - Weeks

Gestational Age - Days

Days Postpartum

Admission Condition: (Select Value)

Admission Status: (Select Value)

Specify Other Status

Admission Reason*: (Select Value)

Specify Other Reason

Principal Source of Payment: (Select Value)

Specify Other Source of Payment

Was Mother Received from Another Hospital?: (Select Value)

From Where?

Was Mother Transferred to Another Hospital?: (Select Value)

To Where?

Date of Discharge from ER/Hospital

Month (Selec) Day (Selec) Year (Selec)

Time of Discharge

Gestational Age - Weeks

Gestational Age - Days

Days Postpartum

Discharge Pregnancy Status* (Select Value)

Deceased at Time of Discharge?* (Select Value)

Name and Location of Facility

Facility Name

Type of Facility* (Select Value)

Specify Other Type of Facility

Facility NPI Number

Level of Maternal Care* (Select Value)

Specify Other Level of Maternal Care

Street

Apartment or Unit Number

City

State (Select Value)

Zip Code

County

Validate Address and Get Geography Context

Clear

Matching Geography Type

Census Tract Certainty Code

Census Tract Certainty Name

Urban Status

Mode of Transportation to Facility (Select Value)

Specify Other Mode of Transportation

Origin of Travel (Select V)

Specify Other Origin

Travel Time to Hospital

Value

Unit (Select)

Internal Transfers - 1 item(s)

item 1 of 1

Date and Time | From Unit | To Unit

mm/dd/yyyy | 00:00:00

Comment(s)

+Add Item

Maternal Biometrics

Height

Feet

Inches

BMI

Admission Weight (lbs)

Physical Examinations and Evaluations - 1 item(s)

item 1 of 1

Date and Time | Exam/Evaluation

mm/dd/yyyy | 00:00:00

Body System | Findings | Performed By (Provider Type)

(Select Value

+Add Item

Psychological Examinations and Assessments - 1 item(s)

item 1 of 1

Date and Time | Exam/Assessment

mm/dd/yyyy | 00:00:00

Findings

Performed By (Provider Type)

+Add Item

Laboratory Tests - 1 item(s)

item 1 of 1

Date and Time

mm/dd/yyyy 00:00:00

Specimen

Test Name

Result

Diagnostic Level

(Select Value)

Comment(s)

+Add Item

Pathology - 1 item(s)

item 1 of 1

Date and Time

mm/dd/yyyy 00:00:00

Specimen

Exam Type

Findings

+Add Item

Onset of Labor

Date of Onset of Labor

Month Day Year

(Selec (Selec (Selec

Time of Onset of Labor

Date of Rupture of Membranes

Month Day Year

(Selec (Selec (Selec

Time of Rupture

Calculate Duration | Clear

Duration of Labor Prior to Arrival (hrs)

Final Delivery Route* (Select Value)

Onset of labor (Select Value)

Multiple Gestation (Select Value)

Pregnancy Outcome* (Select Value)

Specify Other Pregnancy Outcome

Vital Signs - 1 item(s)

item 1 of 1

Date and Time mm/dd/yyyy 00:00:00

Temperature

Heart Rate

Respiration

Systolic BP

Diastolic BP

Oxygen Saturation

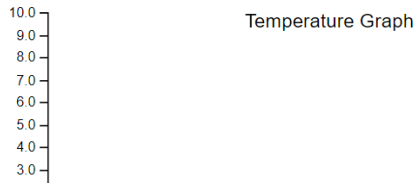
Comment(s)

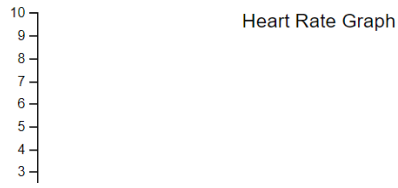
+Add Item

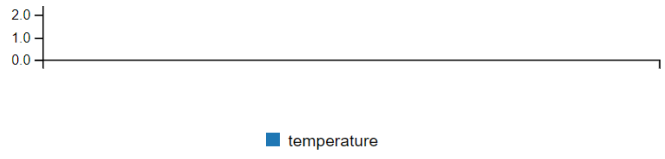
Highest BP

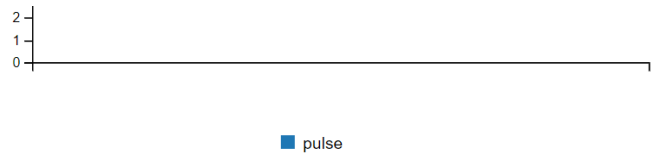
Systolic BP*

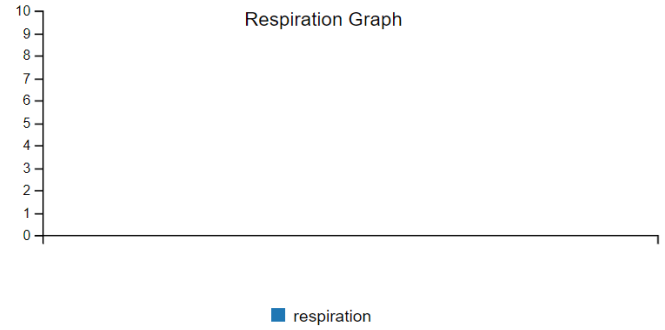
Diastolic BP*

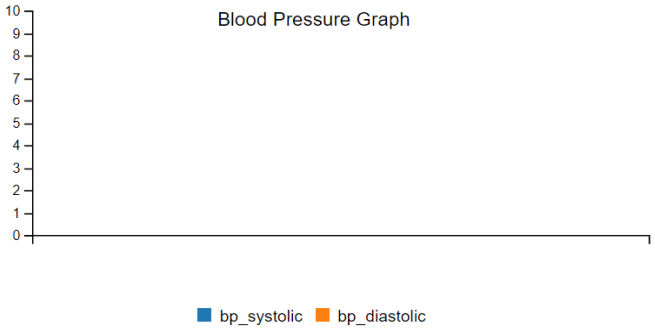












Birth Attendant(s) - 1 item(s)

item 1 of 1

Title	Specify Other	NPI#
(Select Value		

+Add Item

Were There Complications of Anesthesia?* (Select

Anesthesia - 1 item(s)

item 1 of 1

Date and Time		Method	Complications
mm/dd/yyyy	00:00:00		

+Add Item

Were There Adverse Reactions to Any Medications?* (Select

List of All Medications - 1 item(s)

item 1 of 1

Date and Time

mm/dd/yyyy	00:00:00

Medication	Dose/Frequency/Duration	Adverse Reaction?

Comment(s)

+Add Item

Were There Any Surgical Procedures?* (Select Valu

Surgical Procedures - 1 item(s)

item 1 of 1

Date and Time

mm/dd/yyyy 00:00:00

Hospital Unit

Procedure

Performed By (Provider Type)

Outcome

+Add Item

Were There Any Blood or Blood Product Transfusions?*

(Select Value)

Patient Blood Type

Blood Products - 1 item(s)

item 1 of 1

Date and Time

mm/dd/yyyy 00:00:00

Product

Number of Units

Reaction/Complications

+Add Item

Diagnostic Imaging and Other Technology - 1 item(s)

item 1 of 1

Date and Time

mm/dd/yyyy | 00:00:00

Procedure | Target | Findings

+Add Item

Referrals and Consultations - 1 item(s)

× item 1 of 1

Date

mm/dd/yyyy

Specialist Type | Reason | Recommendations

+Add Item

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

At ___ weeks gestation she (or use pseudonym) presented to the _____ (ED/L&D Triage/Other) in a _____ (hospital maternal level of care or trauma level) via _____ (method of transportation) at _____(time). When she arrived, she told medical staff (insert reason for visit). Her weight on admission was _____and her presenting vital signs were Blood pressure: _____ Pulse: _____ Respiration Rate: _____ Temperature: _____ Oxygen Saturation Percentage: _____. She was screened for _____ (describe screening, i.e., embolism, hemorrhage, ectopic, influenza, domestic or intimate partner violence, depression, substance use, etc. Document any treatments or follow-up triggered by the screening.)

When she was examined, her providers found_____. The laboratory blood/urine work performed included _____ (insert the key labs performed) with _____abnormal findings noted. Diagnostic imaging tests performed included _____ with the following abnormal findings noted_____. Her provider diagnosed her with _____and she was admitted to _____ (describe unit) OR transferred to _____OR discharged to_____. Her vital signs upon transfer or discharge were: _____.

(Insert more visits as indicated and include any psychosocial stressors or other contributing factors that were identified in the records.)

Delivery Events (if applicable)
At _____weeks of gestation, she presented to the _____ (ED/L&D Triage/Other) at a (hospital maternal level of care or trauma level). When she arrived, she told medical staff (insert reason for visit). Her weight on admission was _____and her presenting vital signs were_____. She was screened for _____ (describe type of screening, i.e., embolism, hemorrhage, ectopic, influenza, domestic or intimate partner violence, depression, substance use, etc. Document any treatments or follow-up triggered by the screening).

When she was examined, her providers found _____. The laboratory blood/urine work performed included (insert the key labs performed) with abnormal findings noted. Diagnostic imaging tests performed

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Case Folder: Top Folder **Record ID:** TEST-2020-5473

Other Medical Office Visits (Record 1)

Reporting state: test

Date created: user9 7/20/2022 05:12:49

Last updated: user9 7/20/2022 15:19:36

> Back to List of Records

Visit

Date Of Medical Office Visit

Month (Selec) | Day (Selec) | Year (Selec) | Arrival Time | Gestational Age - Weeks

Gestational Age - Days | Days Postpartum

Visit Type* (Select Val) | Specify Other Visit Type | Medical Record No | Reason For Visit Or Chief Complaint

Medical Care Facility

Place Type (Select Value) | Specify Other Place Type | Provider Type (Select Value) | Specify Other Provider Type

Payment Source (Select Valu) | Specify Other | Pregnancy Status (Select Va)

Was this Provider the Primary Prenatal Care Provider?* (Select)

Location Of Medical Care Facility

Street | Apartment or Unit Number

City | State (Select Value) | Zip Code | County

Validate Address and Get Geography Context | Clear

Matching Geography Type | Census Tract Certainty Code | Census Tract Certainty Name | Urban Status

Relevant Medical History - 1 item(s)

item 1 of 1

Finding

Comment(s)

+Add Item

Relevant Family History - 1 item(s)

item 1 of 1

Finding

Comment(s)

+Add Item

Relevant Social History - 1 item(s)

item 1 of 1

Finding

Comment(s)

+Add Item

Vital Signs - 1 item(s)

item 1 of 1

Date and Time

mm/dd/yyyy 00:00:00

Temperature

Heart Rate | Respiration | Systolic BP | Diastolic BP

Oxygen Saturation

Comment(s)

+Add Item

Laboratory Tests - 1 item(s)

item 1 of 1

Date and Time

mm/dd/yyyy 00:00:00

Specimen

Test Name | Result | Diagnostic Level

(Select Value)

Comment(s)

+Add Item

Diagnostic Imaging and Other Technology - 1 item(s)

item 1 of 1

Date and Time

mm/dd/yyyy 00:00:00

Procedure

Target

Finding

+Add Item

Physical Examinations - 1 item(s)

item 1 of 1

Body System

(Select Value)

Finding

Comment(s)

+Add Item

Referrals and Consultations - 1 item(s)

item 1 of 1

Date

mm/dd/yyyy

Specialty

Reason

Recommendations

+Add Item

Prescribed Medications/Drugs - 1 item(s)

item 1 of 1

Date and Time

mm/dd/yyyy

00:00:00

Medication Name

Dose/Frequency/Duration

Adverse Reaction?

Comment(s)

+Add Item

Visit Summary - 1 item(s)

item 1 of 1

Abnormal Findings

Recommendations and Action Plans

+Add Item

Reviewer's Notes About this Medical Office Visit

She (or use pseudonym) presented to (insert type of place: i.e., OB clinic, specialist office, other) on/at (insert date or describe gestational age or postpartum timeframe). When she arrived, she told medical staff (insert reason for visit). Her weight was _____and her presenting vital signs were Blood pressure: ____ Pulse: ____ Respiration Rate: ____ Temperature: ____ Oxygen Saturation Percentage: ____. When she was examined, her provider found_____. The laboratory blood/urine work performed included _____ (insert the key labs performed) with _____abnormal findings noted. Additional diagnostic studies performed showed_____. (Provide details of treatments, care plan, education, or follow-up instructions.)

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Case Folder: Top Folder **Record ID:** TEST-2020-5473

Medical Transport (Record 1)

Reporting state: test

Date created: user9 7/20/2022 05:12:49

Last updated: user5 10/4/2022 05:07:01

Back to List of Records

Date of Transport

Month | Day | Year

(Select | (Select | (Select

Gestational Age - Weeks | Gestational Age - Days | Days Postpartum

Reason for Transport

Patient Conditions (Describe)

Who Managed the Transport? | Specify Other who Managed the Transport

(Select Value)

Transport Vehicle | Specify Other Transport Vehicle

(Select Value)

Timing of Transport

Call Received

mm/dd/yyyy 00:00:00

Depart for Patient Origin

mm/dd/yyyy 00:00:00

Arrive at Patient Origin

mm/dd/yyyy 00:00:00

Patient Contact

mm/dd/yyyy 00:00:00

Depart for Receiving Facility

mm/dd/yyyy 00:00:00

Arrive at Receiving Facility

mm/dd/yyyy 00:00:00

Origin Information

Place of Origin

(Select Value)

Address

Street

Apartment or Unit Number

City

State

(Select Value)

Country

(Select Value)

Zip Code

County

Validate Address and Get Geography Context

Clear

Matching Geography Type

Census Tract Certainty Code

Census Tract Certainty Name

Urban Status

Origin Hospital Trauma Level of Care

(Select Value)

Specify Other Trauma Level of Care

Origin Hospital Level of Maternal Care

(Select Value)

Specify Other Level of Maternal Care

Comments

Procedures Before Transport (Describe)

Procedures During Transport (Describe)

Transport Vital Signs - 1 item(s)

item 1 of 1

Date and Time

mm/dd/yyyy 00:00:00

GA - Weeks

GA - Days

Systolic BP

Diastolic BP

Heart Rate

Oxygen Saturation

Blood Sugar

Comment(s)

+Add Item

Mental Status of Patient During Transport (Describe)

Documented Pertinent Oral Statements Made by Patient or Others on Scene

Destination Information

Name of Facility

Place of Destination

(Select Value)

Specify Other Destination

Address

Street

Unit Number

Matching Geography Type

Census Tract Certainty Code

Census Tract Certainty Name

Urban Status

Estimated Distance (Miles) Between Origin and Destination of Medical Transport

Calculate Distance | Clear

Destination Hospital Trauma Level of Care

(Select Value)

Specify Other Trauma Level of Care

Destination Hospital Level of Maternal Care

(Select Value)

Specify Other Level of Maternal Care

Comments

Reviewer's Notes About Medical Transport

_____ (insert if 911-Emergency Medical Services or medical transport) was notified at _____ (time) by _____ (provider, spouse, partner, etc.) for_____ (reason). Upon arrival at _____ (describe place of origin) she was found to be _____ (weeks gestation OR days/weeks/months postpartum) with _____ (briefly describe condition). (Include if available pertinent oral statements made by patient or others on the scene.) Procedures during transport included_____. (Include mental status of patient during transport if available.) She arrived at_____ (describe destination place/hospital level of maternal care or trauma level) at _____ (time). (Include any barriers or delays noted with ordering or completing the transport.)

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Enable Edit | Save & Continue | Save & Finish

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Undo

Case Folder: Top Folder **Record ID:** TEST-2020-5473

Mental Health Profile

Reporting state: test

Case Status: Abstracting (Incomplete)

Date created: user9 7/20/2022 05:12:49

Last updated: user9 7/20/2022 15:01:26

Were There Documented Preexisting Mental Health Conditions?*

(Select

Documented Preexisting Mental Health Conditions - 1 item(s)

item 1 of 1

Condition

(Select Value)

Duration of Condition

Treatment(s)

Duration of Treatment

Treatment Changed During Pregnancy?

(Select Val

Dosage Changed During Pregnancy?

(Select Valu

If Yes, Mental Health Provider Consultation During this Pregnancy?

(Select

Did Patient Adhere to Treatment?

(Select

Comment(s)

+Add Item

Were There Documented Screenings and Referrals for Mental Health Conditions? - 1 item(s)

item 1 of 1

Date of Screening

mm/dd/yyyy

GA - Weeks

GA - Days

Days Postpartum

Screening Tool

(Select Value)

Specify Other Screening Tool

Referral for Treatment

(Select Value)

Findings

Comment(s)

+Add Item

Was the Decedent TREATED for Any of the Following Mental Health Conditions PRIOR TO the Most Recent Pregnancy? (Select All That Apply)*

- [ ] Anxiety Disorder
- [ ] Bipolar Disorder
- [ ] Depression
- [ ] Psychotic Disorder
- [ ] Substance Use Disorder
- [ ] Other
- [ ] Not Treated
- [ ] Unknown

Specify Other

Was the Decedent TREATED for Any of the Following Mental Health Conditions DURING the Most Recent Pregnancy? (Select All That Apply)*

- [ ] Anxiety Disorder
- [ ] Bipolar Disorder
- [ ] Depression
- [ ] Psychotic Disorder
- [ ] Substance Use Disorder
- [ ] Other
- [ ] Not Treated
- [ ] Unknown

Specify Other

Was the Decedent TREATED for Any of the Following Mental Health Conditions AFTER the Most Recent Pregnancy? (Select All That Apply)*

- [ ] Anxiety Disorder
- [ ] Bipolar Disorder
- [ ] Depression
- [ ] Psychotic Disorder
- [ ] Substance Use Disorder
- [ ] Other
- [ ] Not Treated
- [ ] Unknown

Specify Other

Reviewer's Notes About the Mental Health Profile

She (or use pseudonym) had (insert mental health conditions including substance use disorder either suspected or diagnosed before, during or after pregnancy: include duration and treatment and any changes or barriers associated with the sentinel pregnancy.)

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Enable Edit | Save & Continue | Save & Finish

View Audit Log

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Case Folder: Top Folder **Record ID:** TEST-2020-5473

Informant Interviews (Record 1)

Reporting state: test

Date created: user9 7/20/2022 05:12:49

Last updated: user9 7/20/2022 14:58:56

> Back to List of Records

Date of Interview

Month: (Selec | Day: (Selec | Year: (Selec

Interview Type*: (Select Value)

Specify Other Type:

Information About the Informant

Age Group: (Select Value)

Relationship To Deceased: (Select Value)

Other Relationship:

Interview Narrative:

Reviewer's Notes About the Informant Interview:

MMRIA, TEST

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Case Folder: Top Folder **Record ID:** TEST-2020-5473

Case Narrative

Reporting state: test

Case Status: Abstracting (Incomplete)

Date created: user9 7/20/2022 05:12:49

Last updated: user9 7/20/2022 14:53:46

Case Narrative

Use the pre-fill text below, and copy and paste from Reviewer's Notes below to create a comprehensive case narrative. Whatever you type here is what will be printed in the Print Version.

CTRL+B to bold, CTRL+I to italicize, CTRL+U to underline

Remember the goal is to tell the story of the causes and contributors to the death in a compelling manner that balances the personal, human elements with the clinical. Provide the information the committee needs to complete the MMRIA Committee Decisions Form. Use inclusive and non-stigmatizing language, spell out and/or explain in plain language any use of acronyms, initials, and other clinical shorthand and define clinical terminology when first used. Humanize the story. Avoid victim-blaming framing and be sure to document any such framing in medical or social service records using quotations. Extensive abstraction of clinical records in a non-clinical cause of death may not be necessary or relevant. Use this template as needed.

Delete any portions that are not applicable to the case.

Introduction

She (consider using a pseudonym instead of using "she") was a(n) _____year old who resided in a _____ (insert rural, urban) with (partner, child/ren, etc.). Her medical history included (insert medical history including any diagnosed mental health conditions).

Prenatal Care

For this current pregnancy she entered prenatal care at_____ weeks with _____# visits at a ___ (describe location: clinic, office, etc.) with a _____ (provider type). She had (private, public, or no insurance during prenatal care). Her pre-pregnancy body mass index (BMI) was ____ with a height of ____ and weight of _____. Her pregnancy history included ____# full-term, _____# preterm, _____# abortion/miscarriage and _____# of living children (not including the sentinel pregnancy). Her current pregnancy was known to have (insert complications during pregnancy include identified obstetric risk factors or other medical conditions including mental health and treatments) which impacted this pregnancy. Her family medical history was significant for _____ Referrals during prenatal

The Reviewer's Notes below come from each individual form. To make edits, navigate to each form. This content is included for reference in order to complete the Case Narrative at the top of the page.

Death Certificate

Reviewer's Notes from Case Form

No data entered

Birth/Fetal Death Certificate- Parent Section

Reviewer's Notes from Case Form

No data entered

Birth/Fetal Death Certificate- Infant/Fetal Section

Reviewer's Notes from Case Form: Record 1 – (blank)

No data entered

Social and Environmental Profile

Reviewer's Notes from Case Form

She (or use pseudonym) had the following barriers to accessing healthcare ____ (or state no barriers to accessing healthcare) and had missed appointments due to _____. She had the following barriers to communication (or state no barriers to communication). She had (stable or unstable) housing. Evidence of social or emotional stress included (add factors noted on the Social and Environmental form, including any history of arrest or incarceration, or state no evidence of).

Autopsy Report

Reviewer's Notes from Case Form

She (or use pseudonym) presented to _____ (describe location if applicable) at _____ (describe weeks gestation or postpartum status). (Briefly provide synopsis of events that led to the death): She died at (insert weeks gestation or days/weeks/months postpartum) due to (natural/accidental/violent) causes with an underlying cause of death listed on the death certificate as (insert cause listed on death certificate). Her death (was/was not) referred for autopsy. Autopsy was done by a _____ (OR was not done). Systems Exam (Gross Findings) included _____, Microscopic Exam: _____, Toxicology Results: _____Cause of Death (per autopsy): _____.

(Describe if any bereavement services were documented.) _____.

Prenatal Care Record

Reviewer's Notes from Case Form

For this current pregnancy she entered prenatal care at____ weeks with _____# visits at a ___ (describe location: clinic, office, etc.) with a _____ (provider type). She had (private, public, or no insurance during prenatal care). Her pre-pregnancy body mass index (BMI) was ____ with a height of ____ and weight of _____. Her pregnancy history included ____# full-term, _____# preterm, _____# abortion/miscarriage and _____# of living children (not including the sentinel pregnancy). Her current pregnancy was known to have (insert complications during pregnancy- include identified obstetric risk factors or other medical conditions including mental health and treatments) which impacted this pregnancy. Her family medical history was significant for _____. Referrals during prenatal period were to _____ (provider type) at _____ weeks gestation for _____ (describe reason).

(Insert any additional key prenatal visit details as applicable including barriers to accessing care or noted reasons for missed appointments.)

ER Visits and Hospitalizations

Reviewer's Notes from Case Form: Record 1

At ___ weeks gestation she (or use pseudonym) presented to the _____ (ED/L&D Triage/Other) in a _____ (hospital maternal level of care or trauma level) via _____ (method of transportation) at _____(time). When she arrived, she told medical staff (insert reason for visit). Her weight on admission was _____and her presenting vital signs were Blood pressure: _____ Pulse: _____ Respiration Rate: _____ Temperature: _____ Oxygen Saturation Percentage: _____. She was screened for _____ (describe screening, i.e., embolism, hemorrhage, ectopic, influenza, domestic or intimate partner violence, depression, substance use, etc. Document any treatments or follow-up triggered by the screening.)

When she was examined, her providers found_____. The laboratory blood/urine work performed included _____ (insert the key labs performed) with _____abnormal findings noted. Diagnostic imaging tests performed included _____ with the following abnormal findings noted_____. Her provider diagnosed her with _____and she was admitted to _____ (describe unit) OR transferred to _____OR discharged to_____. Her vital signs upon transfer or discharge were: _____.

(Insert more visits as indicated and include any psychosocial stressors or other contributing factors that were identified in the records.)

Delivery Events (if applicable)
At _____weeks of gestation, she presented to the _____ (ED/L&D Triage/Other) at a (hospital maternal level of care or trauma level). When she arrived, she told medical staff (insert reason for visit). Her weight on admission was _____and her presenting vital signs were_____. She was screened for _____ (describe type of screening, i.e., embolism, hemorrhage, ectopic, influenza, domestic or intimate partner violence, depression, substance use, etc. Document any treatments or follow-up triggered by the screening).

When she was examined, her providers found _____. The laboratory blood/urine work performed included (insert the key labs performed) _____with _____abnormal findings noted. Diagnostic imaging tests performed included _____ with the

following abnormal findings noted_____. Her provider diagnosed her with _____ and she was admitted to _____ (describe unit).

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by a _____ (provider title), method was _____ (describe type of delivery), with _____ anesthesia. Obstetric complications included _____. Fetus/infant was _____ week's gestation and weighed _____ pounds/ounces. Apgar scores were ____ and complications were _____. (Include pertinent information from records and/or informant interviews such as social support, personal complaints, or any other stressors noted by decedent, family, provider, nurse, social work or case management, specialists, chaplain, etc.)

Other Medical Office Visits

Reviewer's Notes from Case Form: Record 1

She (or use pseudonym) presented to (insert type of place: i.e., OB clinic, specialist office, other) on/at (insert date or describe gestational age or postpartum timeframe). When she arrived, she told medical staff (insert reason for visit). Her weight was _____and her presenting vital signs were Blood pressure: ____ Pulse: ____ Respiration Rate: ____ Temperature: ____ Oxygen Saturation Percentage: ____. When she was examined, her provider found_____. The laboratory blood/urine work performed included _____ (insert the key labs performed) with _____abnormal findings noted. Additional diagnostic studies performed showed_____. (Provide details of treatments, care plan, education, or follow-up instructions.)

Medical Transport

Reviewer's Notes from Case Form: Record 1

_____ (insert if 911-Emergency Medical Services or medical transport) was notified at _____ (time) by _____ (provider, spouse, partner, etc.) for_____ (reason). Upon arrival at _____ (describe place of origin) she was found to be _____ (weeks gestation OR days/weeks/months postpartum) with _____ (briefly describe condition). (Include if available pertinent oral statements made by patient or others on the scene.) Procedures during transport included_____. (Include mental status of patient during transport if available.) She arrived at_____ (describe destination place/hospital level of maternal care or trauma level) at _____ (time). (Include any barriers or delays noted with ordering or completing the transport.)

Mental Health Profile

Reviewer's Notes from Case Form

She (or use pseudonym) had (insert mental health conditions including substance use disorder either suspected or diagnosed before, during or after pregnancy: include duration and treatment and any changes or barriers associated with the sentinel pregnancy.)

Informant Interviews

Reviewer's Notes from Case Form: Record 1

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Case Folder: Top Folder **Record ID:** TEST-2020-5473

Committee Decisions

Reporting state: test

Case Status: Abstracting (Incomplete)

Date created: user9 7/20/2022 05:12:49

Last updated: user9 7/23/2022 07:30:24

Form Approved

OMB No. 0920-1294

Exp. Date 04/30/2023

Public reporting burden of this collection of information is estimated to average 24 minutes 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 (0920-1294)

Review Date

mm/dd/yyyy

Pregnancy-Relatedness

(Select Value)

Estimate the Degree of Relevant Information (Records) Available for this Case

(Select Value)

Does Committee Agree with the Underlying Cause of Death Listed on Death Certificate?

(Select Value)

If Pregnancy-Related, Committee Determination of Primary Underlying Cause of Death (PMSS-MM)

(Select Value)

If Applicable: Committee Determination of Secondary Underlying Cause of Death (PMSS-MM)

(Select Value)

Committee Determination of Cause(s) of Death - 1 item(s)

item 1 of 1

Type	Cause (Descriptive)	Comments
(Select Value)		

+Add Item

Committee Determinations on Circumstances Surrounding Death

Did Obesity Contribute to the Death?

(Select Value)

Did Discrimination Contribute to the Death?

(Select Value)

Did Mental Health Conditions Other than Substance Use Disorder Contribute to the Death?

(Select Value)

Did Substance Use Disorder Contribute to the Death?

(Select Value)

Manner of Death

Was this Death a Suicide?

(Select Value)

Was this Death a Homicide?

(Select Value)

If Accidental Death, Homicide, or Suicide, List the Means of Fatal Injury

(Select Value)

Specify Other Means of Fatal Injury

If Homicide, What Was the Relationship of the Perpetrator to the Decedent?

(Select Value)

Specify Other Relationship

Was this Death Preventable?

(Select Value)

Chance to Alter Outcome

(Select Value)

Contributing Factors and Recommendations for Action - 1 item(s)

item 1 of 1

Contributing Factor

Description of Issue

Contributing Factor Class

(Select Value)

Level

(Select Value)

Recommendation of the Committee

Committee Recommendation

Level

(Select Value)

Prevention Type

(Select Value)

Expected Impact

(Select Value)

+Add Item

If recommendations and opportunities for strengthening systems and processes were discussed during the review of this death but would not have prevented this specific death, please document those recommendations here. For example, a recommendation related to the referral of pregnancy-associated deaths to the coroner or medical examiner's office for an autopsy could be listed here.