Form 4

Confidential

Facility Based Maternal Death Review Form email to

reportskhordha@gmail.com

Name and Type of Health Facility (specify) _____

Address _____

Name of Nodal Person _____ Contact No_____

FOR OFFICE USE ONLY

FBMDR No. (Specific to the Place) MCTS No. Month Year

☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ ☐☐

Please fill up the Performa given below

NOTE:

- **MDR Number must be put serially 0001 & so on.**
- **This form must be filled for all Maternal Deaths.**
- **Mark with ✓ wherever applicable.**
- **For Date use Day / Month / Year format. For time use 24 hours clock format.**
- **Complete within 24 hrs.**
- **Make 2 photocopies & send original to MRD, a copy to DNO, and one retained with Nodal Officer for further action.**

Background information of deceased Mother

Full Name _____ Age _____ Inpatient No._____

Medico-legal admission: Yes ☐ No ☐

Complete Address _____

Contact / Mobile No_____

Education: Illiterate ☐ Upto 5th class ☐ 6th to 12th class ☐ Beyond 12th class ☐

Below Poverty Line: BPL Certified ☐ Self certified BPL ☐ Not BPL ☐

1. a. Date and Time of admission: Day☐☐Month☐☐Yr.☐☐ at Hours☐☐ Min.☐☐.

b. Date and time of Death: Day☐☐ Month☐☐ Yr. ☐☐ at Hours ☐☐ Min. ☐☐

c. Duration of Hospital stay: ☐☐Days ☐☐Hours

d. Duration of ICU stay: Days ☐☐ Hours ☐☐ if any

	Days	Hrs.	N.A.	DNK
e. Admission- delivery interval:	☐☐	☐☐	☐☐	☐
f. Admission – death interval	☐☐	☐☐	☐☐	☐

g. Outcome of pregnancy:

1) Abortion ☐	2) Ectopic ☐	3) Live birth ☐

4) Still birth ☐	5) Undelivered ☐	

2. On Admission

a. Complaints at time of admission:_____

b. Obstetric formula on admission

M F

1. Gravida ☐☐ 2. Para ☐☐ 3. Abortions ☐☐ 4. No. of Living children ☐☐

c. Period of gestation:

1) Before 22 weeks ☐	2) Antenatal 22-34 weeks ☐	3) Antenatal ≥ 34 weeks ☐	4) Intrapartum ☐
5) Post-Partum up to 24 hrs ☐	6) Post-natal 24 hrs- 1 week ☐	7) Post-natal- More than 1 week to 42 days ☐	

3. Condition on Admission: 1) Stable ☐ 2) Semi conscious responds to verbal commands ☐ 3) Semi conscious responds to painful stimuli ☐ 4) Unconscious ☐ 5) Brought dead ☐

a. Referral: If referred from outside: i. No. of places visited prior ☐

b. Please fill the table below for the details on transport, referral and type of care given

Place	Home/ Village	Facility 1	Facility 2	Facility 3
Date (DD/MM/YY)				
Time of onset of complication or onset of labour				
Time of calling/ arrival of transport				
Transport used /type				
Time to reach				
Money spent on transport (Rs.)				
Name of Facility / Level of referral				
Attended by Doctor / nurse/ other staff / none				
Reason for referral				
Referral slip (given or not, if yes, attach)				
Treatment given				
Money spent on treatment / medicine/ Diagnostics				
Time spent in facility				

4. Diagnostic at time of admission:

(Please make sure to fill the table with underlying cause given for each condition)

S. No.	Diagnosis → Underlying Cause		
1	Hemorrhage ☐	**I. Abortion** ☐ **II. Ectopic Pregnancy** ☐ **III. Gestational Trophoblastic Disease** ☐	
		IV. Antepartum Bleeding	**a) Placental causes** – Placenta Previa ☐ - Placental abruption: ☐ **b) Late pregnancy Bleeding other than Placental causes:** - Scar dehiscence ☐ - Rupture uterus ☐ - Others, ☐ Specify _____
		V. Intrapartum Bleeding	
		VI. Postpartum bleeding- Atonic ☐ Traumatic ☐ Mixed ☐	
2.	**Hypertensive disorders of pregnancy** ☐	i. Gestational Hypertension ☐ ii. Pre-eclampsia ☐ iii. Eclampsia ☐ iv. Others ☐	
3.	**Labour related Disorders** ☐	i. Normal labour ☐ ii. Prolonged / Obstructed labour ☐ iii. Inversion of Uterus ☐ iv. Retained placenta ☐ v. Any other ☐	
4.	**Medical Disorders** ☐	i. Anaemia ☐ ii. Heart disease ☐ iii. TB ☐ iv. Diabetes ☐ v. Others ☐	
5.	**Infection** ☐	I. Post abortal ☐ II. Antepartum ☐ III. Intrapartum ☐ IV. Post-partum ☐	a) Viral such as Hepatitis/HIV AIDS / Others ☐ b) Malaria ☐ c) Dengue ☐ d) Lower Respiratory Tract Infection ☐ e) Other infections ☐ Specify_____
6.	**Incidental/ Accidental Disorders E.g. Surgical including latrogenic, Trauma, Violence, Anaesthetic complications,** ☐		Specify
7.	**Any other;** ☐		Specify

2. Abortion (to be filled if applicable)

a. Spontaneous ☐ Induced ☐

i. If spontaneous, - Complete ☐ Incomplete ☐

ii. if Induced – Legal ☐ Illegal ☐

b. What was the procedure adopted? Medical methods ☐ MVA ☐ D&E / S&E ☐

Extra Amniotic Instillation ☐ Hysterotomy☐ Others☐

c. Post Abortal Period Uneventful ☐ Sepsis ☐ Hemorrhage☐ Others ☐

d. Was the termination procedure done in more than one center Yes☐ No☐

(If yes, specify the centres visited before coming to this facility

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3. Antenatal Care

a. Did she receive ANC? Yes☐ No☐ Don't know☐

b. If yes, Type of Facility: SC☐ PHC☐ CHC☐ SDH☐ DH☐ Medical College☐

Private hospital ☐ Others☐ specify_____

c. Services provided by: ANM ☐ MO☐ Obstetrician☐ AYUSH☐ Nurse☐ Other specialists☐ specify _____

d. If yes, was she told about any disorder/ complication? Yes☐ No☐ Don't know☐

e. If yes, what was the risk factor identified?

1. Abortion ☐	2. Ectopic pregnancy ☐	3. Vesicular Mole ☐	4. APH ☐
5. Hydramnios / Oligohydamnios ☐	6. Short stature ☐	7. PIH/PE ☐	8. Previous C-section ☐
9. Multiple Pregnancy ☐	10. Grand multi ☐	11. Abnormal presentation/ Position ☐	12. Big baby ☐
13. Anemia ☐	14. Diabetes/ GDM☐	15. Medical conditions (Specify_____) ☐	16. Others (Specify ☐

4. DELIVERY, PUERPERIUM AND NEONATAL INFORMATION **If applicable**

a. Did she have labour pains? Yes☐ No☐

b. If yes, was a partograph used to monitor labour?

i.) Past facility: Yes☐ No☐ Don't know☐

ii.) Current facility: Yes☐ No☐

c. Complications during labour:

1. Eclampsia/ Pre-eclampsia ☐	2. Prolonged labour☐	3. Obstructed labour / Rupture Uterus ☐	4. Intra partum: Hge☐
5. Inversion of Uterus ☐	6. IP sepsis ☐	7. Others ☐	Specify_____

d. Mode of Delivery

1. Undelivered		☐
2. Vaginal	a. Normal - With episiotomy b. Assisted - Forceps - Vaccum c. Breech d. Multiple Pregnancy	☐ ☐ ☐ ☐ ☐ ☐ ☐
3. Caesarean Section	Elective	☐
	Emergency	☐
4. Laparotomy	Rupture uterus	☐
	*Ectopic Pregnancy	☐
5. Indication (CS/Instrumental)		☐

* Although in Ectopic pregnancy woman does not deliver but fetus may be removed during Laparotomy.

e. Anaesthesia (any adverse reaction):

a) General Anaesthesia ☐	b) Reg- Epidural / Spinal ☐	c) Local ☐

f. In which phase of labour did she develop complications?

a) First stage ☐	b) Second stage ☐	c) Third stage ☐	d) Post Birth ☐		
			a. Within ≤ 6 hrs. of birth ☐	b. > 6- ≤ 24 hrs. of birth ☐	c. > 24 hrs. after birth ☐

g. Neonatal Outcome: Alive ☐ Fresh Still birth ☐

Macerated still birth Neonatal death ☐

h. If baby died, probable cause of death:

1. Birth Asphixia ☐	2. Respiratory distress ☐	3. Aspiration including MAS ☐	4. Sepsis ☐
5. Cong Anomalies ☐	6. Preterm ☐	7. Others ☐ Specify _____	

i. Postnatal period : - Uneventful ☐ Eventful ☐

-If Eventful, specify probable cause of death:

1. PPH ☐	2. PE / Eclampsia ☐	3. CVA/ Pulmonary Embolism ☐	4. Sepsis / ARDS ☐
5. Anemia ☐	6. Post op complication ☐	7. Medical conditions Specify _____ ☐	8. Others Specify _____ ☐

5. INTERVENTIONS (Tick appropriate box), Specify other in the last row

Early pregnancy	Antenatal	Intrapartum	Postpartum	Anaesthesia/ ICU
1. Evacuation ☐ 2. Transfusion ☐ 3. Laparotomy / laparoscopy ☐ 4. Hysterectomy ☐	1. Transfusion ☐ 2. Version ☐ 3. Other Surgeries ☐	1. Instrumental del. ☐ 2. Caesarian Section ☐ 3. Hysterectomy ☐ 4. Manual removal of placenta ☐ 5. Conservative Surgery ☐ 6. Transfusion ☐	1. Removal of Retained POC ☐ 2. Laparotomy ☐ 3. Hysterectomy ☐ 4. Transfusion ☐	1. Anaesthesia GA ☐ 2. Spinal ☐ 3. Local ☐ 4. Epidural ☐ 5. ICU Monitoring ☐

a. Blood transfusion given? Yes ☐ No☐

b. If yes, No of units _____☐☐☐☐ Whole Blood ☐ / PRBC☐ / FFP☐ / Platelets / Cryo ☐

c. Specify any transfusion reaction occurred?: Yes☐ No☐

6.Primary diagnosis / condition leading to death _____

7. CAUSE OF DEATH: _____

Part 1 : Antecedent causes (Please mention the cause of death from Box below)

a. **Due to or as consequence of** _____
b. **Due to or as a consequence of** _____
c. **Due to or as a consequence of** _____

8. IN YOUR OPINION WERE ANY OF THESE FACTORS PRESENT?

System	Example	Y	N	Not Known
Personal/ Family	Delay in woman seeking help			
	Refusal of treatment or admission			
	Refusal of admission in previous facility			
Logistical problems	Lack of transport from home to health care facility			
	Lack of transport between health care facilities			
	Lack of assured referral system			
Facilities	Lack of facilities, equipment or consumable			
	Lack of blood/ blood products Lack of OT availability			
Health personnel problems	Lack of human resources Lack of Anesthesist Lack of Obstetricians			
	Lack of expertise, training or education			

9. AUTOPSY: Performed ☐ Not Performed☐

-If performed please report the final diagnosis and send the detailed report later

_____

_____

10. CASE SUMMARY: (please supply a short summary of the events surrounding hospital stay and the death of the patient)

Form filled by the MO on duty

Name & Signature

Designation

Stamp & Date:

Nodal Officer of the Hospital:

Name & Signature

Address of the Institution