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Maternal Mortality Investigation Form

Home Visit and Antenatal Care Report

Patient's Demographics

First Name:	Middle Name(s):
Last Name:	Pet Name(s):
Medical Record Number:	
Date of Birth: *DD/MM/YYYY*	Age:

Marital Status:

◯ Married	◯ Visiting union	◯ Widowed	◯ Separated
◯ Common law	◯ Single	◯ Divorced	◯ Other (specify):

Highest level of Education completed:

◯ No formal schooling	◯ Primary/All Age /Preparatory	◯ Tertiary /Post-secondary	◯ Other
◯ Basic	◯ Secondary/High School	◯ Vocational Skills Training	

What is the patient's employment status?

◯ Employed full time	◯ Self-employed	◯ Housewife
◯ Employed part time (<3 days per week)	◯ Unemployed	◯ PATH programme

Patient's Occupation:

Does the patient fall into any of these risk categories?

◯ Young teenager (16 years and under)	◯ Grand multipara (≥5 pregnancies)	◯ Advanced Maternal Age (>35 years)
◯ Primigravida, 30 years or older	◯ Other (specify)	

Person Interviewed

First Name:	Last Name:

Relationship to the Patient:

◯ Husband/Consort	◯ Father	◯ Sibling	◯ Friend
◯ Mother	◯ Child	◯ Other (specify):	

Were you present when patient died? ◯ Yes ◯ No ◯ Unknown

If no, how long before death were you informed about it? ◯ Yes ◯ No ◯ Unknown

Who told you about the death? ◯ Husband/Consort ◯ Relative ◯ Doctor ◯ Other, Specify

Were you with her when she died? ◯ Yes ◯ No ◯ Unknown

How long after death were you informed about it?

Before (name) was pregnant for the last time, was she generally well? ◯ Yes ◯ No ◯ Unknown

Please describe what happened immediately preceding death

Name of Patient:	Medical Record Number:

ANTENATAL CARE

Did the patient receive antenatal care? ◯ Yes ◯ No ◯ Unknown

If the patient did not attend ANC what is the reason for non-attendance?

Did the patient have a maternal record booklet? ◯ Yes, seen ◯ Yes, not seen ◯ No ◯ Not known

What is the source of primary antenatal care?

Site	Number of Visits
◯ Health Centre	
◯ High Risk Clinic	
◯ General Practitioner	
◯ Obstetrician/ Gynaecologist	
◯ Other:	
TOTAL VISITS	

Date of first visit: *DD/MM/YYYY*	Gestational age at first visit:
Date of last visit: *DD/MM/YYYY*	Gestational age at last visit:

Was the patient referred to high risk clinic? ◯ Yes ◯ No ◯ Unknown

Which high risk clinic was the patient referred to?

Did the patient attend high risk clinic? ◯ Yes ◯ No ◯ Delayed ◯ Unknown

If the patient did not attend high risk clinic what is the reason for non-attendance?

Was the patient contacted by healthcare personnel? ◯ Yes ◯ No ◯ Unknown

Date of first visit: *DD/MM/YYYY*	Gestational age at first visit:
Date of last visit: *DD/MM/YYYY*	Gestational age at last visit:

Conditions managed:

Treatment summary:

Screening Results

Screening results: Haemoglobin _____

ABO Blood Group: ◯ O ◯ A ◯ B ◯ AB ◯ Unknown ◯ Not Done

Rh(D) antigen status: ◯ Positive ◯ Negative ◯ Unknown ◯ Not Done

Sickle Cell Screen: ◯ Positive ◯ Negative ◯ Unknown ◯ Not Done

Name of Patient: | Medical Record Number:

If applicable, what are Sickle Cell Electrophoresis results:

◯ SS	◯ Sβ-Thalassemia	◯ SC
◯ AS	◯ Other (Specify):	

HIV Screen: ◯ Positive ◯ Negative ◯ Unknown ◯ Not Done

Syphilis Screen (VDRL/FTA): ◯ Reactive ◯ Non-Reactive ◯ Unknown ◯ Not Done

If reactive, was patient treated for syphilis? ◯ Yes ◯ No ◯ Unknown

Highest albuminuria result:

◯ No protein detected ◯ Trace ◯ 1+ ◯ 2+ ◯ 3+ ◯ 4+

Last blood pressure on records: _____mm/Hg

Weight: _____ kg/lbs	Height: __-ft _____in/ ____cm	BMI: kg/m^2

Did the patient have oedema? ◯ Yes ◯ No ◯ Unknown

Did the patient experience any of these symptoms before delivery (select all that apply):

◯ Severe headaches	◯ Visual disturbance (seeing spots, seeing double, blindness)	◯ Epigastric pain (stomach ache)
◯ Seizures (fits)	◯ Severe abdominal pain	◯ Swelling of face or hands
◯ High fever	◯ Extremely short of breath	◯ Yellow skin or eyes
◯ Vaginal bleeding	◯ Severe chest pain	◯ Long labour (>12 hours)
◯ Coughing up blood	◯ Severe pain in calves or legs	

Postnatal

Did the patient experience any of these symptoms after delivery (select all that apply):

◯ Severe Bleeding	◯ Bad smelling discharge	◯ C-section wound re-opened
◯ Swollen C-section wound	◯ Severe abdominal pain	

Did the patient have any postnatal admissions? ◯ Yes ◯ No ◯ Unknown

Hospital name:

If yes, when was the patient admitted?

Admitted	Discharged	Discharge Diagnosis	Complications
DD/MM/YYYY	*DD/MM/YYYY*		
DD/MM/YYYY	*DD/MM/YYYY*		
DD/MM/YYYY	*DD/MM/YYYY*		
DD/MM/YYYY	*DD/MM/YYYY*		

Was the patient transferred? ◯ Yes ◯ No ◯ Unknown

Where was the patient transferred to?

Hospital name: | Date of transfer: *DD/MM/YYYY*

Reason for transfer:

Scheduled follow-up date post admission: *DD/MM/YYYY*

Medication Compliance

Was the patient prescribed medication? ◯ Yes ◯ No ◯ Unknown

What medication was prescribed?

Name of Patient:	Medical Record Number:

Was the prescription filled before patient left the health facility? ◯ Yes ◯ No ◯ Unknown

If filling the prescription was delayed what is the reason for the delay?

Did the patient take the medication? ◯ Yes ◯ No ◯ Unknown

Reason for not taking the medication:

HEALTH AND ROUTINE CHILD VISITS

Infant	Vital status	Sex	Current age
	◯ Alive ◯ Deceased	◯ Male ◯ Female ◯ Intersex ◯ Unknown	
	◯ Alive ◯ Deceased	◯ Male ◯ Female ◯ Intersex ◯ Unknown	

Health Centre/Doctor child attends:

Primary caregiver: ◯ Father ◯ Grandparent ◯ Other Relative ◯ Other

If "Other" primary caregiver, please specify:

Notifier's Details		
Date Investigation Completed: *DD/MM/YYYY*		
First Name:	Last Name	
Job Title:		
Phone number:	Email Address:	
Name of Institution:		
Office Number/Street Name:		
Community:	Parish:	
Health Region: ◯ SERHA ◯ NERHA ◯ SRHA ◯WRHA		
Name of Parish MO(H):	Signature of MO(H):	Date signed by MO(H): *DD/MM/YYYY*