Georgia Department of Public Health

Brenda Fitzgerald, MD, Commissioner | Nathan Deal, Governor

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CONFIDENTIAL

MATERNAL MORTALITY REPORT

NOTE:

This form must be completed for the death of a woman while pregnant or within 1 year of end of pregnancy, irrespective of cause.

Medical examiners, coroners and all providers of health care, including but not limited to: hospitals, emergency medical service providers, obstetricians and other physicians, are required to report maternal deaths to the Department of Public Health, Maternal and Child Health Epidemiology Section within 7 days of a maternal death occurrence.

Complete this form in its entirety and attach a copy of the case records. If submitting information from a non-medical facility, omit the clinical section (shaded area on pages 2 -4). Fax forms to 404-657-7307 or email mchepi@dhr.state.ga.us. Reports may also be made through 1-866-PUB-HLTH or 404-657-2850.

DEATH CERTIFICATE NUMBER _____ **HOSPITAL CHART NUMBER** _____

DEMOGRAPHICS OF THE DECEASED

Name _____ Age (years) _____

Race

- ☐ White or Caucasian
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian and Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Multiracial
- ☐ Other; please specify _____
- ☐ Unknown

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Deceased's address
(Street, City, State, Zip) _____

Residence County _____ Residence State (if not GA) _____

LAST DATE OF PREGNANCY OR ESTIMATED DUE DATE (IF PREGNANT) _____

AT TIME OF DEATH

Gravida _____

Para _____

CAUSE OF DEATH

Primary (underlying) cause of death

Final cause of death

Contributory (or antecedent) cause(s)

Classification of the primary cause of death

- ☐ Natural causes
- ☐ Homicide
- ☐ Suicide
- ☐ Pregnancy-related complications
- ☐ Other medical complications
- ☐ Substance abuse
- ☐ Accidental/incidental cause
- ☐ Undetermined

LOCALITY WHERE DEATH OCCURRED

Place of death

- ☐ Home of residence
- ☐ Other residential home
- ☐ Hospital
- ☐ Community health clinic
- ☐ Other; please specify _____
- ☐ Unknown

County

State (if not GA)

CLINICAL INFORMATION

ADMISSION AT INSTITUTION WHERE DEATH OCCURRED OR WHERE IT WAS REPORTED

Date of admission

Time of admission

Date of death

Time of death

Status on admission

- ☐ Aborting/ectopic
- ☐ Antenatal
- ☐ Intrapartum
- ☐ Postpartum

Condition on admission

- ☐ Stable
- ☐ Critically ill
- ☐ Dead on arrival
- ☐ Other; please specify _____

Reason for admission

Was assisted reproductive technology used to achieve pregnancy? ☐ Yes ☐ No

If yes, please specify type _____

ANTENATAL CARE

Did the deceased receive antenatal care? ☐ Yes ☐ No

Antenatal care provider

☐ Obstetrician
☐ Family practice doctor
☐ Certified nurse-midwife
☐ Family nurse practitioner
☐ Women's health nurse practitioner
☐ Other; please specify _____

HIV/AIDS status

☐ Positive ☐ Negative ☐ Unknown

List all medications used during antenatal care

DELIVERY, PUERPERIUM AND NEONATAL INFORMATION

Did labor occur? ☐ Yes ☐ No

Duration of labor (hours: minutes)

Latent phase	Active phase	Second stage	Third stage

Delivery

☐ Undelivered
☐ Vaginal (unassisted)
☐ Vaginal (vacuum/forceps)
☐ Caesarean section

Baby

Birthweight (g) _____ 5 minute Apgar _____

Outcome

☐ Still born ☐ Neonatal death ☐ Alive

Comments on labor delivery, puerperium and neonatal

Interventions

Early pregnancy	Antenatal	Intrapartum
☐ Evacuation	☐ Transfusion	☐ Instrumental delivery
☐ Laparotomy	☐ Version	☐ Symphsiotomy
☐ Hysterectomy		☐ Cesarean section
☐ Transfusion		☐ Hysterectomy
		☐ Transfusion

Postpartum	Other	Other; please specify
☐ Evacuation	☐ General anesthesia	_____
☐ Laparotomy	☐ Epidural anesthesia	
☐ Hysterectomy	☐ Spinal anesthesia	
☐ Transfusion	☐ Local anesthesia	
☐ Manual removal	☐ Invasive monitoring	
	☐ ICU ventilation	

CLINICAL INFORMATION ENDS

Autopsy performed? ☑ Yes ☐ No

If yes, please report the gross findings and send the detailed report later

CASE SUMMARY

Please provide a short summary of the events surrounding the death

THIS FORM COMPLETED BY

Name _____ Title _____

Office/Department _____

Case Number (if assigned by reporting office) _____

Telephone _____ Fax _____

Date _____ Signature _____