**MATERNAL DEATH REPORTING FORM (CONFIDENTIAL)**
**(For Home delivery)**

| **General Information (1/3)** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Name of the deceased | | | Age | | Hospital register no. | | Nationality | |
| Permanent address | Village/town | | Gewog | | Dzongkhag | | CID number | |
| MCH Reg.No. | | | | | | | | |
| **1.INFORMATION OF MOTHER** | | | | | | | | |
| **1.1. Socio-economic status** | | | | | | | | |
| Marital status | □ Unknown | □ Married | □ Not married | □ Widowed | □ Divorced | | | |
| Education | □ None | □ Primary | □ Secondary | □ Graduate | □ NFE | □ Other (specify) | | |
| Occupation | □ Housewife | □ Farmer | □ Office worker | □ Other (specify) | | | | |
| Present Address | Village/town | | Gewog | | Dzongkhag | | | |
| Distance from the nearest health facility | BHU | by walk | | and/or | by vehicle | | | |
| | Hospital | by walk | | and/or | by vehicle | | | |
| Husband' occupation | □ Farmer □ Office worker □ Other (specify) | | | | | | | |
| Husband Education | □ None | □ Primary | □ Secondary | □ Graduate | □ NFE | □ Other (specify) | | |
| **1.2. Medical History** | | | | | | | | |
| □ Heart disease | □ Diabetes | □ Hypertension | □ Thyroid disease | □ TB | □ Other (specify) | | | |

| **1.3. Past Obstetric History** | | | | **2.4. Obstetric Complications** | | | | |
|---|---|---|---|---|---|---|---|---|
| Year of pregnancy | Type of pregnancy | Place of delivery | Any complications | □ PIH | □ GDM | □ APH | □ Multiple Pregnancy | □ UTI |
| | | | | □ PROM | □ Fever | □ Polyhydroamnios (AFI) | | □Pre-eclampsia |
| | | | | □ Oligohydroamnios (AFI) | | □ Other (specify) | | |
| | | | | **2.5. Antenatal care** | | | | |
| | | | | Gravida | | Para | | |
| | | | | No. of child living | | No. of miscarraiges | | |
| No. of still birth | | ANC attended or not | □ Not done □ Done. If not attended please give seasons | | | | | |
| Date of last ANC | | No. of Visits | | Date first ANC | | LMP | | |
| EDD as per LMP | | Ultrasound | □ YES □NO | POG at 1st scan | | EDD as per Ultrasound | | |
| Place of ANC | □ Hospital □ BHU □ ORC | | HIV test done or not | □ YES □NO | | | | |
| Blood group | | VDRL/RPR | □ YES □NO | HBsAg | □ YES □NO | TPHA done or not | | □ YES □NO |
| Td received | □ YES □NO | OGTT | □ YES □NO | PPBS | □ YES □NO | FBS | | □ YES □NO |
| Any problems detected during pregnancy (mention the problems) | | | | | | | | |
| Whether the problems were managed properly or not | | | | | | | | |

| **2. DELIVERY RECORD** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Sex of child | □ Male | □ Female | □ Ambigous | Place of Delivery | | Date of birth | |
| Time of birth | ……. AM □PM | Duration of labor | | | | | |
| Delivery conducted by | □ RElatives □ Health Assistant □ Nurses □ BHW □others specify | | | | Placenta | □ Expelled normally □ Retained | |
| Out come of the delivery | □ Alive □Stillbirth □IUFD □ Single □Twins □Triplets | | | | | | |

| MATERNAL DEATH REPORTING FORM | | | |
|---|---|---|---|
| **Information of Home Death** | | | **(2/3)** |
| **3. EVENTS AT THE TIME OF DEATH** | | | |
| Date of Death | | Time of death | |
| Place of death | □ Home □ on the way to health facility □ Other (specify) | | |
| Time called for help | | | |
| Management done including referral after help was called | | | |
| | | | |
| If help not sought (give reasons) | | | |
| **3.1: At What stage did the death occur?** | | | |
| □ After miscarraige □Before labour □During labor (□first stage □second stage) □after delivery of baby | | | |
| **4. REASONS OF DEATH** | | | |
| Source of information (Specify) | | | |
| Family's reason of death | | | |
| Probable cause of death | | | |
| **5. EVENT TRACING/RECOMMENDATIONS** | | | |
| **5.1: Chronological event tracing (Detailed case history)** | | | |
| | | | |
| **5.2: Recommendations for future** | | | |
| | | | |
| **Name of the physician** | | **Signature** | |
| **Name of the EMoNC focal person completing this form** | | | |
| Designation | | Contact number | |
| Signature | | Date/Time | |

| **6: Hospital/District maternal mortality committee report (can use extra sheet if required)** | | | **(3/3)** |
|---|---|---|---|
| Name of the Chairperson of the MM Committee | | | |
| Designation | | Signature | |
| Verified | □YES □NO | If verified (Probable cause of death | |
| If not verified (give reasons) | | | |
| 6.1: Comments on events and the managmement of the patient | | | |
| | | | |
| 6.2: Avoidable factors | | | |
| | | | |
| 6.3: Suggestions for future improvement of the services | | | |
| | | | |
| 6.4: Final Diagnosis | | | |
| | | | |
| **Submit list of committee members** | | | |