MATERNAL DEATH REPORTING FORM (CONFIDENTIAL)
(For Hospital delivery)

General Information (1/4)								
Name of the health facility			Dzongkhag		Name of the deceased			
Mother's MCH Reg.No.			Age		Hospital register no.		Nationality	
Permanent address	Village/town		Gewog		Dzongkhag		CID number	

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	Apgar score	1 min		PoG at birth	……..Weeks		……Days
			5 min					
Birth weight in grams		FHS on admission		□ YES □NO				
Mode of delivery	□ SVD □ Vacuum □ Forceps		Presentation at delivery			Labor	□ Induced □ Spontaneous	
	□ Emergency CS □ Elective CS □Breech			Partograph Maintained		□ YES □NO □Not Applicable		
	If not maintained patograph give reasons						Duration of labor	
Delivery conducted by	□ Obstrician □ GDMO □ Health Assistant □ Nurses			Placenta	□ Spontaneous expellsion □CCT □MRP □Retained			
Out come of the delivery	□ Alive □Stillbirth □IUFD □ Single □Twins □Triplets							
Intrapartum complications	□ Lack of progress □ Prolong 2nd stage labor □ Obsructed labor □Fetal distress □Meconium □ cord prolapse □ Abruptia Placenta							
	□ Other (specify)							
Postpartum Hemmorrhage (PPH)	□ YES □NO	If PPH present: indicate the estimated blood lose		……in ml	Blood transfussion	□ YES □NO		

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Information of Hospital Death (2/4)					
3. EVENTS AT THE TIME OF DEATH					
Date of admission		Time		Am/Pm	
Cause of admission		Time		Am/Pm	
Clinical diagnosis		Date of death			
Place of death	□ Labour room □ OT □ Maternity ward □ En route □Emergency room □ICU □ Other (specify)				
Primary cause of death		Secondary cause of death			
3.1: At What stage the death occur?					
□ After miscarraige □Before labour □During labor (□first stage □second stage) □after delivery of baby					
Postpartum death (mention the no. of days after delivery)		……..days after delivery			
4: REFERRAL INFORMATION (fill this up only if the patient is refered					
Referred from		Reasons for referral			
Date of referral		Time of referral		Appropriate referral	□ Done □ Not done
What are the management carried out prior to referral of the patient (mention in the box below				whether the management was	□adequate □not adequate
				6. ANTEPARTUM DEATH	
				Estimated gestation at death	……weeks
				Any evidence of induced miscarriages (if any give reasons)	
				Any evidence of ectopic pregnancy:	
				Any evidence of rupture uterus:	
				Any evidence of APH:	
5. RECORD OF SURGICAL PROCEDURES					
Indication of surgery					
Type of operation:	□ suction Evac. □ Evac and Curettage □Emergency C Section □ Elective CS □ Caesarean Hysterectomy □ Laporatomy				
PAC	□ done □ not done □ not applicable	Surgeon	□ Gynecologist □ General surgeon □others specify		
Any pre operative complications (specify)					
Any per operative complications (specify)					
Type of anesthesia	□ G/A □ Spinal □ Epidural □ IVA □ Sedation		Anesthetist	□ Anesthesiologist □ Nurse anesthetist	
Any anesthetist complications (specify)					
Any problem in recovery stage (specify)					
Post operative complication (Specify)					
Any avoidable factors					

MATERNAL DEATH REPORTING FORM

EVENT TRACING/RECOMMENDATION (3/4)

6. Chronological event tracing (Detailed case history)

7. Recommendations for future

Name of the physician			Signature	
Name of the EMoNC focal person completing this form				
Designation			Contact number	
Signature			Date/Time	

8. Hospital/District maternal mortality committee report (can use extra sheet if required) (4/4)			
Name of the Chairperson of the MM Committee			
Designation		Signature	
8.1: Comments on events and the managmement of the patient			
8.2: Avoidable factors			
8.3: Suggestions for future improvement of the services			
8.4: Final Diagnosis			
Submitt the list of committee members			