

**DEPARTMENT OF HEALTH
CONFIDENTIAL**

MATERNAL DEATH NOTIFICATION FORM

For office use only: Department of Health Office case number

NOTE:

1. *This form must be completed for all deaths, including abortions and ectopic gestation related deaths, in pregnant women or within 42 days after termination of pregnancy irrespective of duration or site of pregnancy*
2. *Mark with an (X) where applicable (? means unknown)*
3. *Attach a copy of the case records to this form*
4. *Complete the form in duplicate within 7 days of a maternal death. The original remains at the institution where the death occurred and the copy is sent to the person responsible for maternal health in the province*

Address of contact person (Person responsible for Maternal Health in the Province)

1. LOCALITY WHERE DEATH OCCURRED

Province Health District

Institution Locality

CHC Clinic	Level 1 Hospital	Level 2 Hospital	Level 3 Hospital	Private Hospital	Other - Specify
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2. DETAILS OF DECEASED

Name Inpatient No.

Address

Age (yr) Race AF = African; CO = Coloured; In = Indian; WH = White; OT=Other

At time of death
Gravida Para Gestation (weeks) Days since delivery/abortion
(or at delivery) (if not applicable enter 99)

3. ADMISSION AT INSTITUTION WHERE DEATH OCCURRED OR FROM WHERE IT WAS REPORTED

Date of admission: 24h min

Date of death: 24h min

On admission:	Aborting/ectopic	Antenatal	Intrapartum	Postpartum
Condition on admission:	Stable	Critically ill	Dead on arrival	Other - specify

Diagnosis at moment of death:	Abortion	Ectopic pregnancy	Not in labour	In labour	Postpartum
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Reason for admission:

Referral from another centre? Y N If "Y" from

4. ANTENATAL CARE

Did she receive antenatal care? Y N ? If "Y", at what locality? ? Primary Secondary Tertiary Private Other

Antenatal care provider	Specialist	Med.Off/ GP	Adv. Midwife	Midwife/ Reg. nurse	Other - Specify	Total Number of visits	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>
	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 50px; height: 20px;" type="text"/>	<input style="width: 150px; height: 20px;" type="text"/>		<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>

Antenatal Risk Factors	Risk	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> ?	
	History	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	Specify: <input style="width: 300px; height: 25px;" type="text"/>
	Hypertension	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	Other - Specify <input style="width: 150px; height: 40px;" type="text"/>
	Proteinuria	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	
	Glycosuria	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	
	Anaemia	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	
	Abnormal lie	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	
	Previous C/Section	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	HIV Status <input type="checkbox"/> + <input type="checkbox"/> - <input type="checkbox"/> ?

Comments on antenatal care - List any medication

5. DELIVERY, PUERPERIUM AND NEONATAL INFORMATION

Did Labour occur? Y N If "Y", was a partogram used Y N ? Duration of labour (hours:min) ? Latent phase Active phase Second stage Third stage

Delivery (Tick appropriate box)	Undelivered	Vaginal (unassisted)	Vaginal Vacuum/forceps	Caesarean section
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Baby Birthweight (g) 5 min Apgar Outcome Stillborn Neonatal death Alive

Comments on labour delivery and puerperium

6. INTERVENTIONS (Tick appropriate box)

Early pregnancy		Antenatal		Intrapartum		Postpartum		Other	
Evacuation		Transfusion		Instrumental del.		Evacuation		Anaesthesia - GA	
Laparotomy		Version		Symphiotomy		Laparotomy		Epidural	
Hysterectomy				Caesarean section		Hysterectomy		Spinal	
Transfusion				Hysterectomy		Transfusion		Local	
				Transfusion		Manual removal		Invasive monitoring	
Other - specify								ICU ventilation	

Comments on interventions

7. CAUSE OF DEATH (See Guidelines)

Codes
(For office use only)

Primary (underlying) cause of death: Specify:			
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Final cause of death: Specify:			
Contributory (or antecedent) cause/s: Specify:			

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

System	Example	Y	N	?	Specify
Personal/Family	Delay in woman seeking help				
	Refusal of treatment or admission				
Logistical systems	Lack of transport from home to health care facility				
	Lack of transport between health care facilities				
	Health service - Health service communication breakdown				
Facilities	Lack of facilities, equipment or consumables				
Health personnel problems	Lack of human resources				
	Lack of expertise, training or education				

Comments on potential avoidable factors, missed opportunities and substandard care

