**Abstraction**

SMM (recorded cause) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SMM Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

MR # or PATIENT ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code of patient residence \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abstraction Date \_\_\_\_/\_\_\_\_\_/\_\_\_\_ Abstractor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital Level 1  2 3 4 Birth center Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient Characteristics** | | | | | |
| Age **\_\_** Weight/Height / Body mass index (BMI) at first prenatal visit Most recent BMI \_\_\_\_ | | | | | |
| **Race** (Indicate race patient identifies)  Choose an item.  **Hispanic or Latina**  No  Yes  Unknown | |  | | **Obstetric History**  Gravida \_\_\_\_\_\_\_  Para \_\_\_ Term \_\_\_ Premature \_\_ Aborted \_\_ Living \_\_\_  # Previous fetal deaths \_\_\_\_  # Previous infant deaths \_\_\_\_ | |
| **Prenatal Care (PNC)** | | | | | |
| **Yes ☐** Week PNC began \_\_\_\_\_ Week unknown Yes ☐ No ☐ Number of PNC visits \_\_\_\_ Visit # unknown Yes ☐ No ☐  **No ☐**  **Unknown PNC status** ☐ | | | | | |
| **Discipline of Primary PNC Provider** (choose one)  Choose an item. | | | **Prenatal care source/location**  Choose an item. | | |
| **Planned/intended place of delivery**  Choose an item. | | | **Timing of maternal morbidity**  Choose an item. | | |
| **Maternal Transport** (during peripartum period)  No Choose an item.  **Yes** From facility \_\_\_\_\_\_\_\_ to facility \_\_\_\_\_\_\_\_\_\_\_\_  **Unknown** | | | **Perinatologist consultation** (during peripartum period)  **No** Choose an item.  **Yes** Provider type: \_\_\_\_\_\_\_\_\_\_\_  **Unknown** | | |
| **Delivery Information**  Gestational age at time of morbidity \_\_\_\_\_\_\_\_\_\_  Singleton  Multiple  (If multiple fill out additional delivery information per fetus) | | | | | |
| **Birth status** Choose an item. | **Labor** Yes **☐** No **☐** | | | | **Delivery type** Choose an item. |
| **If C-Section**  Type of C-section Choose an item. | **If C-Section**  Primary reason for C-Section Choose an item. | | | | |
| **Type of anesthesia** Choose an item. | | | **Primary payer source** Choose an item. | | |

**Case Narrative**

Should include brief synopsis focused on the specific severe maternal morbidity that occurred that allow you to address the disease specific questions. It should be concise and pertinent to the particular SMM and include appropriate time line, evaluation, and be in chronologic format. Try to identify key moments that impacted care

**Case Analysis**

**Assessment**

MR# or PATIENT ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_

Date of event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **1. Morbidity Category  ICU Admission Transfused 4 or more units  Other \_\_\_\_\_** | |
| **2. Sequence of Morbidity**  Indicate the course of events:  *Clinical Cause of Morbidity: 1& 2 reflect what initiated the final cause resulting in the severe morbidity. 3 is the final cause*  *For example: 1. Preeclampsia 2. uncontrolled hypertension 3 intracranial bleed,*  *So that 1, caused 2, that resulted in 3 – the severe morbidity* | **1.**  **2.**  **3.** |
| **3. Primary Cause of Morbidity** Choose an item.  If trauma indicated as primary cause of morbidity: Choose an item.  Other cause \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Resolution**

Refer to the SMM Outcome Factors Guide (pg. 7) of the SMM Review Long Form to determine contributing factors and opportunities

|  |
| --- |
| **Opportunity to Alter Outcome** Strong Possible None |
| **If opportunity to alter outcome present were opportunities largely: Circle all that apply**  **Provider**  **System**  **Patient** |
| **List up to 3 things that could be done to alter outcome:** |
| **Identify practices that were done well and should be reinforced:** |
| **Recommendations for system, practice, provider improvements:** |

This form was originally developed by the California Pregnancy-Associated Mortality Review (CA-PAMR) using Title V MCH funding and is adapted with permission from the California Department of Public Health, Maternal, Child and Adolescent Health Division. Sacramento, CA

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Lawton B, Macdonald EJ, Brown SA, Wilson L, Stanley J, Tait JD, Dinsdale RA, Coles CL, Geller SE. Preventability of severe acute maternal morbidity. AJOG 2014;210:557.