**Abstraction**

Date

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

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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** | | |
| Did race/ethnicity contribute to morbidity?Yes **☐** No **☐** Maybe ☐  Did language barrier contribute to morbidity? Yes **☐** No **☐** Maybe ☐  Did specific social determinants of health contribute to the morbidity? Yes **☐** No **☐** Maybe ☐ | | | | | |
| **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. | | | | |
|  | | | **Primary payer source** Choose an item. | | |

|  |
| --- |
| **Resolution**  Review the SMM Outcome Factors Guide (pg. 7) of the SMM Review Form to determine contributing factors and opportunities |
| **Opportunity to alter outcome** Yes  No |
| **Which factor(s) offers the opportunity to alter outcomes (select 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** |

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**Hypertensive disease**

1. Was hypertension measured and recognized appropriately?
2. Did the patient receive nifedipine?
3. Was severe hypertension treated in a timely fashion?
4. Was the patient transferred to the hospital?
5. Were any complications related to hypertensive disease managed appropriately?

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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