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| MANDATORY REPORT OF A MATERNAL DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Michigan Department of Health and Human Services | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Please send this report immediately after the death of a woman who was currently pregnant or was pregnant with 365 days of death. Report the event regardless of where the patient died. **Please provide as much detail as possible, and submit any associated medical records (e.g., discharge summaries, autopsy reports, EMS reports, etc.) along with this reporting form.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. | Name of woman | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | Last First Middle Maiden | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | Address | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | Street City State Zip | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| 2. | Date of death | | | |  | | | | | | | | | | | | | | |  | | 2. | | Time of death | | | | | |  | | | |  |
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| 3. | Date of birth | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
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| 4. | Woman’s Social Security Number | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | |  |
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| 5. | Pregnancy Status: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | Pregnant at Death | | | | | | | | | | | Estimated Gestation | | | | | |  | | | | | | | | | | |  | | | | |
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|  |  | Live birth in past year | | | | | | | | | | |  | | Miscarriage/Stillbirth in past year | | | | | | | | | | | | | | | | | | | |
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|  | Date of delivery | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
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|  | Name of birth hospital (if known) | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | Name of Obstetrician (if known) | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | Names of other hospitals woman was admitted to during the past year | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  |
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| 6. | Location of death | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| 7. | Hospital of death | | | | | |  | | | | | | | | | | | | | | |  | | | | City |  | | | | | | |  |
|  | If different from 5. above | | | | | | | |  | | | | | | | | | | |  | |  | | | |  |  | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. | Woman’s medical record number | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | |
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| 9. | Name of attending physician at death | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
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| 10. | Autopsy | | | | | |  | | None | | | | | | |  | | Yes – at site of death | | | | | | | | | |  | | | Yes – at other site | | | |
|  | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |  | | |
| 11. | Cause of death | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| 12. | Name of medical examiner or hospital pathologist | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  |
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| 13. | Name of facility or address where autopsy was performed | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  |
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| 14. | Report prepared by | | | | | |  | | | | | | | | | | | | | | |  | | | Date | |  | | | | | | |  |
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| 15. | Name of organization | | | | | | |  | | | | | | | | | | | | | |  | | | Telephone | | | |  | | | | |  |
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| **PLEASE RETURN THIS FORM AND THE ASSOCIATED MEDICAL RECORDS TO:**  Maternal Mortality Surveillance  Bureau of Epidemiology and Population Health  Michigan Department of Health and Human Services  South Grand Building  333 South Grand Ave, 2nd Floor  Lansing, MI 48933 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |