Maternal Medical Record Face Sheet

(To be completed on every record selected)

<table>
<tr><td rowspan="2">MRN #</td><td colspan="3">Last Name: _____</td></tr>
<tr><td>Age</td><td>G / T / P / A / L</td><td>Prenatal Care:
Yes ☐ No ☐</td></tr>
<tr><td>Maternal History/
Complications/Diagnoses:</td><td colspan="3">Placenta Accreta Spectrum Disorder (PASD) ☐
Obstetrical Hemorrhage ☐ Massive Hemorrhage and Transfusion ☐
Hypertensive Disorder (requiring treatment) ☐ Sepsis ☐ VTE ☐
Shoulder Dystocia ☐ Behavioral Health Disorders ☐
Other: _____</td></tr>
<tr><td></td><td colspan="3">Transfer In ☐ Transfer Out ☐ ICU ☐ Antepartum Admission ☐
Other Admission (ER, Surgery, Med/Surg, etc.) ☐
Readmission within 30 days ☐</td></tr>
<tr><td>Delivery Category:</td><td colspan="3">Vaginal ☐
Forceps Assist ☐ Vacuum Assist ☐

TOLAC ☐ Successful VBAC: Yes ☐ No ☐

Cesarean Section ☐
Scheduled ☐ Urgent ☐ Emergent ☐</td></tr>
<tr><td>ICU Team Consult:
Yes ☐ No ☐</td><td colspan="3">PASD Team Consult: Yes ☐ No ☐</td></tr>
<tr><td>Patient Arrival Date:</td><td>ICU Admit Date:</td><td>MFM Consult Date:</td><td>MFM at Bedside Date:</td></tr>
<tr><td>Delivery Date:</td><td>Gestational
Age/Weight:</td><td>Resuscitation or Delivery
Complications:
Yes ☐ No ☐</td><td>Neonatal Team
Present:
Yes ☐ No ☐</td></tr>
<tr><td>Specialty Consult:
Yes ☐ No ☐</td><td colspan="3"></td></tr>
<tr><td>Telemedicine: Yes ☐ No ☐
Specialty _____</td><td colspan="3">Surgeries other than Cesarean-section (include returns to OR):</td></tr>
<tr><td>Ancillary Services:</td><td colspan="3">Social Services ☐ Behavioral Health ☐ Spiritual Care ☐
Lactation ☐ Dietary ☐ Other: _____</td></tr>
<tr><td>Screening and Risk
Assessments Performed:</td><td colspan="3">Substance Abuse/Addiction ☐ Drugs ☐ Depression ☐
Other Behavioral Health ☐ VTE ☐ Sepsis ☐
Shoulder Dystocia ☐ Obstetrical Hemorrhage ☐ PASD ☐
Postpartum Depression Screen at Discharge ☐ Other: _____</td></tr>
</table>

Patient Final Disposition Date:	Transfer ☐ Home ☐ Death ☐		Expired
Total Length of Stay:	ED: Hours _____ Expired ☐	Antepartum Days: _____ Delivered: Yes ☐ No ☐	ICU: Days _____ Expired ☐ Transferred ☐ Discharged ☐

1) PI Event Identified and Level of Harm Event: Level of Harm: _____ Date: _____	Primary Review: Yes ☐ No ☐ Date: _____ Secondary Review: Yes ☐ No ☐ Date: _____ Tertiary Review: Yes ☐ No ☐ Date: _____
Action Items that Occurred as Result of Review:	Loop Closure: Yes ☐ No ☐ Ongoing ☐
2) PI Event Identified and Level of Harm Event: Level of Harm: _____ Date: _____	Primary Review: Yes ☐ No ☐ Date: _____ Secondary Review: Yes ☐ No ☐ Date: _____ Tertiary Review: Yes ☐ No ☐ Date: _____
Action Items that Occurred as Result of Review:	Loop Closure: Yes ☐ No ☐ Ongoing ☐
3) PI Event Identified and Level of Harm Event: Level of Harm: _____ Date: _____	Primary Review: Yes ☐ No ☐ Date: _____ Secondary Review: Yes ☐ No ☐ Date: _____ Tertiary Review: Yes ☐ No ☐ Date: _____
Action Items that Occurred as Result of Review:	Loop Closure: Yes ☐ No ☐ Ongoing ☐
Outreach Education to Transferring Facility/Transport:	Identified and Documented: Yes ☐ No ☐