



Rapid report and surveillance form

1.0 Woman's details

Ethnic group:^{1*} (enter code, please see Definitions for codes)

Race:^{1*} (enter code, please see Definitions for codes)

1.2 Was this woman born in Canada? Yes No Unknown

If No, Country of birth:

1.3 Was this woman a Canadian citizen? Yes No Unknown

If No,

State country of citizenship:

How long in Canada before death:

If <24 months, number of months

If ≥24 months, number of years

Unknown

and please tick one of the following

Born in Canada Landed immigrant Other (Specify) _____ Unknown

1.4 Did the woman speak/understand English? Yes No

1.5 Living arrangements: (Tick all that apply)

Own Rent Public Housing

Living alone Living with partner Living with relative

Homeless Other Unknown

1.6 Maternal Height: cm Not known



1.7 Maternal first recorded Weight: kg Unknown

1.8 Pre-pregnancy BMI Unknown

1.9 Smoking status: Never Pre-pregnancy During Pregnancy
Post-Partum Unknown

1.10 Was this woman known to misuse alcohol or other substances?

Yes
No
Unknown

1.11 Domestic Abuse:

Did this woman experience domestic abuse prior to pregnancy? Yes No Unknown

Was domestic abuse identified during pregnancy? Yes No Unknown

Was the woman asked about abuse during her antenatal visits?

Yes No Not documented No antenatal visits Unknown

1.12 Mental Health:

Did this woman have a current mental health condition? Yes No Unsure Unknown

If Yes, please specify details:

1.13 Was the infant taken or to be taken into care? Yes No Unknown

2.0: Previous Obstetric History

2.1 Is the previous obstetric history known? Yes No

If No, please go to Section 3.



2.2 Previous pregnancies

Number of completed pregnancies beyond 22 weeks

Number of live births

Number of stillbirths/late fetal losses

Number of previous caesarean sections

If no previous pregnancies, *please go to section 3.*

2.3 Did the woman have any previous pregnancy problems?^{2*} Yes No Unknown

If **Yes**, please specify details:

3.0: Previous Medical History

3.1 Did the woman have any pre-existing or antenatal conditions?^{3*} Yes No Unknown

If **Yes**, please specify details:

3.2 Has this woman ever had a mental health diagnosis? Yes No Unsure Unknown

If **Yes**, please specify details:



Was this history identified at first appointment?

Yes No Unknown

4.0: This Pregnancy

4.1 Final Estimated Date of Birth (EDB^{4*})? MM YY Unknown

4.2 Was this a multiple gestation? Yes No

If Yes, please specify the number of fetuses, including this baby

4.3 Was this pregnancy the result of assisted reproduction/IVF? Yes No Unknown

4.4 Did the woman receive antenatal care? Yes No Unknown

4.5 What was the intended place of birth?

Level 1 Facility Level 2 Facility Level 3 Facility Birth Centre

At home Other (please specify) _____ Unknown

4.6 Were there problems in this pregnancy^{2*}? Yes No Unknown

If Yes, please specify details:

4.7 Were there post-partum problems following this pregnancy^{2*}? Yes No Unknown

If Yes, please specify details:



5.0: Delivery

5.1 Was the woman undelivered at the time of death?

Yes No

If **No**, where did the woman deliver?

Level 1 Facility Level 2 Facility Level 3 Facility Birth Centre

At home Ambulance Other (please specify) _____

5.2 Was this delivery an early pregnancy loss?

Yes No

Best estimate of gestational age:

If **Yes**, please state if loss was due to Ectopic Miscarriage Termination Other

If **Other**, please specify:

5.3 Was labour induced?

Yes No

5.4 Did the woman labour?

Yes No

5.5 What was the mode of delivery?

Spontaneous Assisted Vaginal C-section

If delivered by c-section, was it:

Pre-labour After onset of labour Perimortem

5.6 Did the woman ever have anaesthesia?

Yes No

If **Yes**, what method(s) were used? GA Epidural Spinal Combined Epidural/Spinal

Other _____



6.0: Outcomes

Section 6a: Woman

6a.1 Was the woman transferred to critical care? Yes No Unknown

Or to a facility with a higher level of care? Yes No Unknown

6a.2 Was there any major maternal morbidity in this pregnancy?^{5*}

Yes No If Yes, please specify _____ Unknown

6a.3 Was the woman discharged from hospital after delivery and before death?

Yes No Unknown Never in hospital

6a.4 What was the date and time of death? DD MM YY hh mm

OR tick if time not known

What was the initially presumed cause of death? _____

What were the cause(s) of death stated on the death certificate?

Was autopsy performed?

Hospital Coroner/Medical Examiner Other No

If Yes, what was the diagnosis on the death certificate?

6a.5 Where did the woman die?

Hospital At home Other healthcare facility Ambulance Other _____