# PMMRC

## Perinatal and Maternal Mortality Review Committee

### RAPID REPORTING FORM FOR A PERINATAL DEATH - MOTHER

**Please use the "*Guidelines for the completion of the mother and baby forms following a perinatal death March 2014 Version 10" to help* completion of this form. You can obtain these guidelines from www.otago.ac.nz/pmmrc**

Both the PMMRC mother and baby forms need to be completed by the Lead Maternity Carer or other clinician for any baby dying from 20 weeks gestation (i.e. ≥$20^0$, or **if gestation is unknown** a birth weight ≥400gm) including all terminations, to before 28 completed days of life (i.e. up to midnight on the 27th day).

This Mother form should be submitted electronically before the Baby form is submitted.
**Compulsory entries are: - Number of babies born in this pregnancy, number of perinatal losses linked to this pregnancy and Mother's NHI**

We understand that you may not know the answer to some of the questions but we would appreciate it if you can answer as much as possible.

If sending in written copies please send this together with the PMMRC Baby Form (see address and fax numbers at back of form).

**PLEASE COMPLETE WITHIN 48 HOURS OF THE BABY'S DEATH IF POSSIBLE**

**Personally identifiable information (of the mother, baby or lead maternity carer) collected on this form will be kept confidential. The information included in reports by the PMMRC is grouped and non-identifiable.**

1. **How many perinatal losses are linked to this pregnancy** ☐
2. **Mother's NHI:** ☐
3. **First name(s):** ☐ **Surname:** ☐

   **Mother's other name(s):** ☐
4. **Date of birth:** ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY)
5. **Usual residential address at time of delivery:**

| | |
|---|---|
| Property /house name | ☐ |
| Flat/Unit number | ☐ |
| Street Number/rapid number (rural) | ☐ |
| Street name | ☐ |
| Suburb /locality | ☐ |
| Town/City | ☐ |
| Country (if not New Zealand) | ☐ |
| Post Code | ☐ |

**6. Ethnicity:** *(Select all relevant)*

- ☐ New Zealand European
- ☐ Māori
- ☐ Samoan
- ☐ Cook Island Māori
- ☐ Tongan
- ☐ Niuean
- ☐ Chinese
- ☐ Indian
- ☐ Other (such as Dutch, Japanese, Tokelauan),

If other please state: ☐

**Please state the country of birth?**

- ☐ New Zealand
- ☐ Australia
- ☐ England
- ☐ China
- ☐ India
- ☐ South Africa
- ☐ Samoa
- ☐ Cook Islands
- ☐ Other Please specify: _____

**Source of ethnicity information:** *(Select all relevant)*

- ☐ Woman
- ☐ Family/Whanau
- ☐ DHB Patient Registration Form
- ☐ LMC notes
- ☐ Clinical notes
- ☐ NHI details
- ☐ Other please state: _____

**7. Maternal height** ☐☐☐ cms **and weight** ☐☐☐ kg (earliest measured in pregnancy)

*(If not available please measure height and weight)*

**8. Past obstetric history: previous pregnancies**:

**Gravidity**: ☐☐ **Parity:** ☐☐ *(Do not include index pregnancy in parity. Multiple births counted as one)*

**Unknown** ☐

| Date of Delivery | Place of birth **(Please state)** | Gestation (weeks) | Pregnancy Outcome (see below for codes) | Method of delivery (see below for codes) | Birth weight | SGA <10th centile | Complications (see below for codes) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**Pregnancy Outcome** – LB = Live born, SM = spontaneous miscarriage, TOP = termination of pregnancy, E = ectopic pregnancy, SB = stillbirth, END = early neonatal death (<7 days age), LND = late neonatal death (7 days – 27 days), CYD = Child and Youth Death (28 days – 24 years), U = unknown
**Method of Delivery** NVD = Normal vaginal delivery, OV = Operative vaginal delivery, VB = Vaginal breech, CS = Caesarean Section, U = unknown
**Complications** - NIL = No complications, HE = hyperemesis, APH = Ante partum haemorrhage/Abruption, CxS = cervical stitch, GDM = Gestational diabetes, PET = Pre-eclampsia, Other = please comment in summary section, U = unknown

***All the following questions relate to this pregnancy**

**9. Family violence**

Has mother suffered family violence during this pregnancy?

**Yes** ☐ **No** ☐ **Not Asked** ☐ **Unknown** ☐

*(If the answer was "Yes" to the above answer the question below)*

Was she offered referral to a relevant support services?

**Yes** ☐ **Yes but declined** ☐ **No** ☐ **Unknown** ☐

**10. History of infertility for >12 months before this pregnancy**:

**Yes** ☐ **No** ☐ **Unknown** ☐

**11. Fertility treatment for this pregnancy:** *(Select all relevant)*

Artificial insemination - donor ☐

Artificial insemination – husband/partner ☐

Clomiphene citrate ☐

Follicle-stimulating hormone ☐

Intra-cytoplasmic sperm injection ☐

In vitro fertilisation ☐ If yes, how many embryos were transferred? ☐

Surgery to increase fertility ☐

Insulin sensitisers e.g. Metformin, ☐

Letrozole ☐

Other ☐

If other please state: ☐

**Was treatment in New Zealand?** **Yes** ☐ **No** ☐ **Unknown** ☐

**If overseas, please state where** _____

**12. Intended place of birth:**

☐ Home

☐ Birthing Unit

☐ Hospital level 1

☐ Hospital level 2

☐ Hospital level 3

☐ Other

☐ Unknown

☐ Not registered

Please state name of place/unit/hospital:

☐

**13. Actual place of birth:**

☐ Home

☐ Birthing Unit

☐ Hospital level 1

☐ Hospital level 2

☐ Hospital level 3

☐ Other

☐ Fetus still in utero

☐ Unknown

Please state name of unit/hospital:

☐

*(If the intended place of birth is different to the actual place of birth then answer the below question)*

**14. When did mother's transfer to actual place of birth occur?**

Before labour ☐

In labour ☐

Unknown ☐

**15. Lead Maternity Carer**

Please select the mother's lead maternity carer (LMC) at time of first registration and at birth?

| *(Select one in each column)* | **LMC at booking** | **LMC at birth*** |
|---|---|---|
| Not registered | ☐ | ☐ |
| Self-employed midwife | ☐ | ☐ |
| DHB care | ☐ | ☐ |
| General Practitioner | ☐ | ☐ |
| Obstetrician (private) | ☐ | ☐ |
| Unknown | ☐ | ☐ |

***For 'LMC at booking' to be different to 'LMC at birth' a new registration must have been completed.**

**16. Please indicate who was clinically responsible for the woman's care at time of birth** *(Select one)*

- No care ☐
- Self-employed midwife ☐
- DHB care ☐
- General Practitioner ☐
- Obstetrician (private) ☐
- Unknown ☐

**If clinical responsibility is different, to 'LMC at booking' when did this transfer of clinical responsibility occur?**

**a) Antenatal** ☐ **b) Intrapartum** ☐

**17. Antenatal Procedures:** *(Select all relevant)*

| | **Yes** | |
|---|---|---|
| Scan at ≤22 gestation | ☐ | *(If "Yes")* How many scans? ☐ |
| 1st trimester screening (MSS1) | ☐ | |
| 2nd trimester screening (MSS2) | ☐ | |
| Anatomy scan | ☐ | *(If "Yes")* Gestation of 1st anatomy scan ☐ **weeks** ☐ **days** |
| | | *(If repeated)* gestation of 2nd anatomy scan ☐ **weeks** ☐ **days** |
| Chorionic villus sampling | ☐ | |
| Cervical suture | ☐ | |
| Amniocentesis | ☐ | |
| Doppler studies | ☐ | |
| Growth scan | ☐ | |
| External cephalic version | ☐ | |
| Fetocide | ☐ | |
| Amnioreduction | ☐ | |
| Fetoscopic laser treatment | ☐ | |
| Traditional massage | ☐ | |
| Other | ☐ | If other please state: |
| No antenatal procedures | ☐ | |
| Unknown | ☐ | |

**18. a. Smoking at 1st registration with a LMC (cigarettes)?**

**Yes** ☐ **No** ☐ **Unknown** ☐

**b. Smoking status at birth (cigarettes)?**

**Never smoked** ☐

**Current non-smoker**

Stopped before this pregnancy ☐

Stopped < 16 weeks gestation ☐

Stopped ≥16 weeks gestation ☐

Previous status unknown ☐

**Current smoker** ☐

How many cigarettes ☐☐ per day ☐ Unknown

**Smoking status unknown** ☐

**c. Smoking cessation support?**

No ☐ Yes – by LMC/clinician only ☐ Yes – referred to external agent ☐

Offered but declined ☐ Unknown ☐

**19. Maternal use of alcohol and other drugs:** **Yes** ☐ **No** ☐ **Unknown** ☐

*(If "Yes" select all drugs used by mother during this pregnancy)*

| | **during 1st trimester** | **month prior to birth** | **Describe** |
|---|---|---|---|
| Alcohol | ☐ | ☐ | |
| Amphetamine/P | ☐ | ☐ | |
| Cocaine | ☐ | ☐ | |
| Ecstasy | ☐ | ☐ | |
| Hallucinogens | ☐ | ☐ | |
| "Herbal highs" | ☐ | ☐ | |
| Synthetic cannabis | ☐ | ☐ | |
| Marijuana | ☐ | ☐ | |
| Opiates | ☐ | ☐ | |
| Methadone | ☐ | ☐ | |
| Petrol/paint/glue | ☐ | ☐ | |
| Other | ☐ | ☐ | |

If other please state: ☐

**20. Antenatal visits before fetal death/or delivery:**

**a.** Total number of visits from antenatal record ☐☐ **Unknown** ☐

**b**. Gestation at first antenatal visit with LMC: ☐☐ weeks **Unknown** ☐

**c**. Gestation at first antenatal visit with any health provider: ☐☐ weeks **Unknown** ☐

**21. Mother's clinical history** *(including any diagnoses made in this pregnancy)*

| *(Please answer all questions)* | Yes | No | Unknown |
|---|---|---|---|
| **a.** Asthma | ☐ | ☐ | ☐ |
| **b.** Diabetes | ☐ | ☐ | ☐ |

*If "Yes" answered for part b answer the below)*

☐ Type 1 diabetes

☐ Type 2 diabetes

☐ Impaired glucose tolerance

| | | | |
|---|---|---|---|
| **c.** Epilepsy | ☐ | ☐ | ☐ |
| **d.** Heart condition | ☐ | ☐ | ☐ |

*(If "Yes" selected for part d answer the below)*

☐ Congenital heart condition

☐ Rheumatic heart disease

☐ Coronary artery disease

☐ Other cardiac condition - if other please state: ☐

| | | | |
|---|---|---|---|
| **e.** Thyroid abnormality | ☐ | ☐ | ☐ |

*(If "Yes" answered for part e answer the below)*

☐ Hypothyroidism

☐ Hyperthyroidism

☐ Other - if other please state: ☐

| | | | |
|---|---|---|---|
| **f.** Inflammatory bowel disease | ☐ | ☐ | ☐ |
| **g.** Systemic lupus erythematosus | ☐ | ☐ | ☐ |
| **h.** Other autoimmune disorder | ☐ | ☐ | ☐ |
| **i.** Mental health disorder | ☐ | ☐ | ☐ |

*(If "Yes" answered for part i answer the below)*

☐ Depression

☐ Psychotic disorder

☐ Other - if other please state: ☐

| | | | |
|---|---|---|---|
| **j.** Renal disease | ☐ | ☐ | ☐ |
| **k.** Venous thromboembolism | ☐ | ☐ | ☐ |
| **l.** Blood disorders | ☐ | ☐ | ☐ |

*(If "Yes" answered for part l answer the below)*

☐ Anaemia

☐ Thalassaemia trait

☐ Thrombophilia

☐ Other - if other please state: ☐

| | | | |
|---|---|---|---|
| **m.** Hypertension | ☐ | ☐ | ☐ |

*(If "Yes" answered for part m answer the below)*

☐ Chronic/essential hypertension

☐ Secondary hypertension

**Mother's clinical history *continued*** | **Yes** | **No** | **Unknown**

**n.** Cervical surgery ☐ ☐ ☐

**o.** Urinary tract infection ☐ ☐ ☐

**p.** Uterine abnormality ☐ ☐ ☐

**q.** Uterine surgery ☐ ☐ ☐

**r.** Other ☐

If other please state: ☐

**22. a. Screening for diabetes in pregnancy:** | **Yes** | **No** | **Unknown** | **Declined**

☐ ☐ ☐ ☐

**b. Gestational Diabetes confirmed** ☐ ☐ ☐

**c. Laboratory results**

**i) HbA1c at booking**

Result:_____ mmol/mol Date __/__/__

**ii) HbA1c (≥20 weeks)** *(record highest result)*

Result:_____ mmol/mol Date __/__/__

**iii) Polycose** *(record highest result)*

Result: ☐☐.☐ mmol/L Date__/__/__

**iv) Glucose Tolerance Test** *(record highest result)*

Result: Fasting: ☐☐.☐ mmol/L 2hour: ☐☐.☐ mmol/L Date__/__/__

| | **Yes** | **No** | **Unknown** |
|---|---|---|---|
| **23. Was this a multiple pregnancy?** | ☐ | ☐ | ☐ |

*(If "Yes" is answered for Question 23 answer the below)*

**1.** Number of fetuses/babies at first ultrasound in pregnancy: ☐

**2.** Number total number of babies born in this delivery, including stillbirths? ☐

**3.** Was a fetal reduction performed? If YES, please describe: ☐

**4.** What type of multiple:

☐ Dichorionic diamniotic

☐ Monochorionic diamniotic

☐ Monoamniotic

☐ Other Multiple – please describe chorionicity ☐

☐ Unknown

*(If "Yes" selected in Question 23 answer Question 24)*

**24. If multiple pregnancy, please note NHI of all fetuses/babies:**

☐ First **NHI** ☐

☐ Second **NHI** ☐

If more than two babies in this pregnancy please state other NHI:

☐

**25. Was there any vaginal bleeding related to this pregnancy?** *(Please complete both)*

| | Yes | No | Unknown |
|---|---|---|---|
| Before 20 weeks | ☐ | ☐ | ☐ |
| After 20 weeks | ☐ | ☐ | ☐ |

**26. Obstetric conditions**

**Did the mother have any of these conditions in this pregnancy?** *(Select all relevant)*

| | Yes | No | Unknown |
|---|---|---|---|
| **a.** Hypertension | ☐ | ☐ | ☐ |

*(If "Yes" answered part "a" answer one of the below)*

☐ Gestational hypertension

☐ Pre-eclampsia

☐ Pre-eclampsia with chronic hypertension

☐ Eclampsia

☐ Chronic hypertension

☐ Unspecified

| | | | |
|---|---|---|---|
| **b.** Preterm labour | ☐ | ☐ | ☐ |
| **c.** Prolonged rupture of membranes | ☐ | ☐ | ☐ |

*(If "Yes" answered to part "c" answer one of the below)*

☐ Preterm - rupture < 37 weeks gestation

☐ Term - rupture ≥ 37 weeks gestation

| | | | |
|---|---|---|---|
| **d.** Cholestasis of pregnancy | ☐ | ☐ | ☐ |
| **e.** Confirmed maternal infection | ☐ | ☐ | ☐ |

*(If "Yes" answered to part "e" answer the below)*

**Kind of infection:**

☐ Pyelonephritis

☐ Lower urinary tract infection

☐ Other infection

If other please state: ☐

| | | | |
|---|---|---|---|
| **f.** Trauma | ☐ | ☐ | ☐ |

*(If "Yes" answered to part "f" answer one of the below)*

**Kind of trauma:**

☐ Vehicular

☐ Violent personal injury or assault

☐ Other (e.g. falls)

If other please state: ☐

| | | | |
|---|---|---|---|
| **g.** Other obstetric condition | ☐ | ☐ | ☐ |

If other please state: ☐

| | | | |
|---|---|---|---|
| **h.** Surgery in pregnancy | ☐ | ☐ | ☐ |

Please state type of surgery: ☐

**27. Fetal growth restriction was suspected before fetal demise:** *(Select one)*

- ☐ No
- ☐ Yes but no scan performed
- ☐ Yes and confirmed by scan
- ☐ Unknown
- ☐ Yes but normal growth on scan

| | Yes | No | Unknown |
|---|---|---|---|
| **a.** Was a customised growth chart generated for this woman antenatally? | ☐ | ☐ | ☐ |

| **28. Folic Acid taken in this pregnancy?** *(Please complete both)* | Yes | No | Unknown |
|---|---|---|---|
| Folic Acid taken pre-pregnancy? | ☐ | ☐ | ☐ |
| Folic Acid taken first trimester? | ☐ | ☐ | ☐ |

**29. Was there consultation with an obstetrician during pregnancy?**

- ☐ Obstetrician was lead maternity carer
- ☐ Yes *(If "Yes" please - select all relevant below)*
- ☐ No
- ☐ Unknown

**What was/were the reason(s) for the obstetrician consultation?**

- ☐ Prolonged pregnancy (>41 weeks)
- ☐ Age of mother
- ☐ Breech
- ☐ Recurrent miscarriage
- ☐ Mother's request
- ☐ Stillbirth (this pregnancy)
- ☐ Previous Stillbirth
- ☐ Suspected size of fetus ☐ *(If "Yes")* large fetus ☐ small fetus ☐
- ☐ Previous intrauterine growth restriction
- ☐ Previous Caesarean section
- ☐ Renal
- ☐ Cardiac
- ☐ Hypertension
- ☐ Prolonged rupture of membranes
- ☐ Cholestasis
- ☐ Other medical ☐ Please specify: _____
- ☐ Surgery in pregnancy
- ☐ Significant infection
- ☐ Multiple pregnancy
- ☐ Antepartum haemorrhage
- ☐ Diabetes
- ☐ Unstable lie
- ☐ Fetal Abnormality
- ☐ Raised BMI
- ☐ Other reason

If other please state:

**30. Was the mother referred to any other healthcare services (apart from midwifery & obstetrics) during pregnancy?**

| | Yes | No | Unknown |
|---|---|---|---|
| | ☐ | ☐ | ☐ |

*(If "Yes" answered to Question 30 answer the below – select all relevant)*

| | | | |
|---|---|---|---|
| Medical *(includes MFM, non-obstetric specialists)* | ☐ | ☐ | ☐ |
| Mental health | ☐ | ☐ | ☐ |
| Drug and alcohol | ☐ | ☐ | ☐ |
| Social | ☐ | ☐ | ☐ |
| Other service | ☐ | | |

If other please state: _____

**31. Induction**

| | Yes | No | Unknown |
|---|---|---|---|
| *(If "Yes", please select all that apply)* | ☐ | ☐ | ☐ |

**a) Medication/method used**

- ☐ Balloon
- ☐ Cervidil
- ☐ Misoprostol – if yes dose: ☐☐☐ mcg
- ☐ Mifegyne
- ☐ Artificial rupture of membranes Time: ☐☐:☐☐ 24 hour clock Date __/__/__
- ☐ Other, please specify: _____
- ☐ PG gel 1 mg
- ☐ PG gel 2 mg
- ☐ PGE2 tablets
- ☐ Oxytocin

**b) Reason for induction:**

- ☐ Post dates
- ☐ Pre-eclampsia
- ☐ APH
- ☐ Diabetes
- ☐ Maternal request
- ☐ Other, please specify: _____
- ☐ Intrauterine fetal death
- ☐ Intrauterine growth restriction
- ☐ Fetal Abnormality
- ☐ Prolonged rupture of membranes

**32. Augmentation:** **Yes** ☐ **No** ☐ **Unknown** ☐

*(If "Yes", please select all that apply)*

**Medication/Method:**

- ☐ Artificial rupture of membranes Time: ☐☐:☐☐ 24 hour clock Date __/__/__
- ☐ Oxytocin
- ☐ Other, please specify: _____

**33. Analgesia in labour** **Yes** ☐ **No** ☐ **Unknown** ☐

*(If "Yes" answer the below, select all relevant)*

- Opiate ☐
- Nitrous oxide ☐
- Epidural ☐
- TENS* ☐ **Transcutaneous electrical nerve stimulation*
- Unknown ☐
- Other ☐ Please specify: _____

**34. Bath or pool during labour:** | **Yes** | **No** | **Unknown**

Did part of labour occur in bath/pool? ☐ ☐ ☐

*(If "Yes" answered in Question 34 answer the below)*

Was the baby born in bath/pool? ☐ ☐ ☐

**35. Mode of birth:** *(Select one for each baby/fetus this pregnancy)*

| | **First baby/fetus** | **Second baby/fetus** |
|---|---|---|
| Normal vaginal delivery | ☐ | ☐ |
| Vaginal breech | ☐ | ☐ |
| Operative vaginal delivery | ☐ | ☐ |
| Caesarean section | ☐ | ☐ |
| Unknown/not stated | ☐ | ☐ |

If more than two babies/fetuses please state: ☐

*(If "Vaginal breech" selected for Question 35 answer the three questions below)*

**a. When was breech diagnosed?**

☐ Breech identified prior to labour

☐ Breech identified during labour

**b. Mode of delivery**

☐ Assisted

☐ Extraction

☐ Spontaneous

**c. Was an anaesthetic administered?** **Yes** ☐ **No** ☐ **Unknown** ☐

*(If "Yes", please select one)*

General ☐ Local ☐

Spinal ☐ Other ☐

Epidural ☐ If other please state: ☐

*(If "Operative delivery"" selected for Question 35 answer the two questions below)*

**a. Mode of delivery**

☐ Forceps low ☐ Ventouse low

☐ Forceps mid-cavity ☐ Ventouse mid

☐ Forceps mid-cavity with rotation ☐ Ventouse mid-rotation

**b. Was an anaesthetic administered?** **Yes** ☐ **No** ☐ **Unknown** ☐

*(If "Yes", please select one)*

General ☐ Local ☐

Spinal ☐ Other ☐

Epidural ☐ If other please state: ☐

*(If "Caesarean section" selected for Question 35 answer the three questions below)*

**a. Were forceps tried first?**

☐ Forceps/Ventouse attempted **before** Caesarean

☐ Forceps/Ventouse **not** attempted before Caesarean

**b. Type of caesarean section**

If the baby born by caesarean section, please state the type of caesarean section

**Planned** - no labour ☐ **Unplanned** - no labour ☐

**Planned** - during labour ☐ **Unplanned** - during labour ☐

**c. Was an anaesthetic administered?** **Yes** ☐ **No** ☐ **Unknown** ☐

*(If "Yes", please select one)*

General ☐ Local ☐

Spinal ☐ Other ☐

Epidural ☐ If other please state: ☐

**36. Maternal outcome:**

☐ Alive and generally well

☐ Alive but with serious morbidity e.g. admitted to ICU, hysterectomy or stroke.

☐ Dead *(Please add further details if morbidity or mortality has occurred)*

**37. Placenta:**

**a)** Placenta weight: ☐☐☐☐ gm **or** placenta not weighed ☐ Unknown ☐

**b)** Placental examination: ☐ Not examined ☐ Normal ☐ Some abnormalities

*(If "Some abnormalities" select all relevant)*

☐ Retroplacental clot

☐ Gritty/ calcified

☐ Circumvallate placenta

☐ Other If other please state: ☐

**38. Umbilical cord examined?** **Yes** **No** **Unknown**

*(If "Yes" selected answer the below)* ☐ ☐ ☐

**Any problems with cord?** *(Select all relevant)* ☐ ☐ ☐

| | | | | | | |
|---|---|---|---|---|---|---|
| True knot | ☐ | *(If selected answer)* | tight knot | ☐ | loose knot | ☐ |
| Cord round neck | ☐ | *(If selected answer)* | tight around | ☐ | loose around | ☐ |
| Cord round limbs or body | ☐ | *(If selected answer)* | tight around | ☐ | loose around | ☐ |
| Torsion/spring-like cord (e.g. hypercoiled) | ☐ | | | | | |
| Marginal/ velamentous insertion | ☐ | | | | | |
| Abnormal cord thickness | ☐ | *(If selected answer)* | thin cord | ☐ | thick cord | ☐ |
| Meconium stained | ☐ | | | | | |
| Tear in cord | ☐ | | | | | |
| 2 vessels | ☐ | | | | | |
| Other abnormality | ☐ | If other please state: ☐ | | | | |

**39. Summary**

Please provide any information you think relevant that was not covered in the previous questions, which you consider may have contributed to the outcome. *(Please continue over page)*

**Form completed by:**

**Name:**

**Designation:**

**Contact details: Phone-**
**Email-**

**Date:**

**LMC name and address if different to clinician completing the form**

_____
_____
_____
_____

**Please send (mail or fax) the completed form to:**

National Coordination Service
Perinatal and Maternal Mortality Review Committee (PMMRC)
Department of Obstetrics and Gynaecology
University of Auckland
Private Bag 92019
Auckland
Phone 09 923 4440
Fax 09 303 5969