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Collection: LOGIN
Contains: DATSTAT_ALTPID



Salud Mesoamerica Initiative (SMI)
Login page for the Health Facility Survey

Question: DATSTAT_ALTPID
Required



ID:

Collection: MEDICAL_RECORD_REVIEW
Contains: MRR_LOG_IN, MRR_OBSTETRIC

Medical Record Review

Collection: MRR_LOG_IN
Contains: MRR_DATE, MRR_INTERVW_ID1, MRR_INTERVW_ID2, MRR_TYPE_UNIT, DISTRICT_ID, FACILITY_ID

Please note that all questions in this section refer to the measurements and procedures performed on the mother, unless otherwise specified

Question: MRR_DATE
Required



1. Today's Date:

 (DD/MM/YYYY)

Question: MRR_INTERVW_ID1
Required



2. Interviewer ID 1:

Question: MRR_INTERVW_ID2



3. Interviewer ID 2:

Question: MRR_TYPE_UNIT
Required

Scale Summary		
Code	Label	Show-If
1	Health Clinic / Health Post / Mobile Unit	Never Shown
2	Community Hospital	
3	Regional hospital	



4. What type of medical facility is this?

- ☐ Health Clinic / Health Post / Mobile Unit
☐ Community Hospital
☐ Regional hospital

Question: DISTRICT_ID
Required

Scale Summary		
Code	Label	Show-If
2001	Orange Walk	
2002	Corozal District	
2004	Cayo District	
995	Other	



5. District ID:

- ☐ Orange Walk
☐ Corozal District
☐ Cayo District
☐ Other

Question: FACILITY_ID

Scale Summary		
Code	Label	Show-If
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Device Type	Percentage
Smartphone	85%
Tablet	92%
Smartwatch	88%
Smart TV	95%
Smart speaker	90%
Smart home security camera	82%
Smart doorbell	85%
Smart light bulb	80%
Smart thermostat	78%
Smart plug	82%
Smart lock	75%
Smart car	70%
Smart home assistant	85%
Smart home energy monitor	88%
Smart home weather station	90%
Smart home air purifier	82%
Smart home water leak detector	85%
Smart home smoke detector	80%

☐ Other (specify):

Show if: (MRR_TYPE_UNIT = 3:[Regional hospital]) or (MRR_TYPE_UNIT = 2:[Community Hospital])

Contains: MRR SELECTION, MRR SELECTION BACKUP, MRR WOM DEL COMP, MRR GENERAL, SEPSIS, HEMORRHAGE, PRE-ECLAMPSIA, ECLAMPSIA

Review the Hospital Admission and Exit Record Sheet and record the diagnosis and discharges codes that are included

Principal ICD-10 code	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	o	<input type="checkbox"/>	Not recorded	<input type="text"/>	o	<input type="checkbox"/>	Not recorded
Second ICD-10 code	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	o	<input type="checkbox"/>	Not recorded	<input type="text"/>	o	<input type="checkbox"/>	Not recorded
Third ICD-10 code	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	o	<input type="checkbox"/>	Not recorded	<input type="text"/>	o	<input type="checkbox"/>	Not recorded
Fourth ICD-10 code	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	o	<input type="checkbox"/>	Not recorded	<input type="text"/>	o	<input type="checkbox"/>	Not recorded
Fifth ICD-10 code	<input type="text"/>	<input type="text"/>	.	<input type="text"/>	o	<input type="checkbox"/>	Not recorded	<input type="text"/>	o	<input type="checkbox"/>	Not recorded

Scale Summary		
Code	Label	Show-If
1	Sample determined by IHME (including backups)	
2	Electronic sample at the health facility	
3	Manual sample at the health facility	
995	Other:	



☐ Sample determined by IHME (including backups)
☐ Electronic sample at the health facility
☐ Manual sample at the health facility
☐ Other:

Show if: (MRR_SELECTION = 1:[Sample determined by IHME (including backups)])

Scale Summary		
Code	Label	Show-If
1	Yes	
2	No, this was a backup medical record determined by IHME	
995	Other:	

☐ Yes

☐ No, this was a backup medical record determined by IHME

☐ Other:

Question: MRR_WOM_DEL_COMP

Minimum checks: 1

 10. Did the woman have any of the following complications (Select ALL that apply)?

- ☐ Sepsis
☐ Hemorrhage
☐ Severe pre-eclampsia
☐ Eclampsia
☐ None

Jump-To: JMP3

Description:

Jump-To-Item: NO_COMPL

Jump-If: (MRR_WOM_DEL_COMP is-any-of)


Collection: MRR_GENERAL

Contains: WOM_ADM_DATE, WOM_ADM_TIME, WOM_ADM_REFFROM, WOM_REF_ACCOMFROM, WOM_REF_DATEFROM, WOM_REF_TIMEFROM, WOM_REF_NAMEFROM, WOM_REF_TYPEFROM, WOM_BOOKING, MRR_AGE, MRR_MAR_STAT, MRR_LITERACY, MRR_ETHNICITY, MRR_EDU, WOM_SICKLE, WOM_DIST_ID, WOM_GESTAGE, WOM_BABYCOMPL, WOM_BABYBIRTH_WHERE, WOM_BABYBIRTH_DATE, WOM_BABYBIRTH_TIME

Question: WOM_ADM_DATE

Required

Scale Summary		
Code	Label	Show-If
1	Yes:	
-1	Not recorded	

 11. Please note if the following was recorded:

Date of admission


☐ Yes: (DD/MM/YYYY)

☐ Not recorded

Question: WOM_ADM_TIME

Required

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

 12. Please note if the following was recorded:

Time of admission


☐ Time: (HH:MM)

☐ Not recorded

Question: WOM_ADM_REFFROM

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

 13. Was the woman referred/transferred from another medical facility?

☐ Yes


☐ No

Question: WOM_REF_ACCOMFROM

Required

Show if: (WOM_ADM_REFFROM = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Yes, by a doctor	
2	Yes, by a nurse	
995	Yes, by another worker	
0	No	
-1	Not recorded	

 14. Was the woman accompanied by a health facility worker?

☐ Yes, by a doctor

☐ Yes, by a nurse

☐ Yes, by another worker

☐ No

☐ Not recorded

Question: WOM_REF_DATEFROM

Required

Show if: (WOM_ADM_REFFROM = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	


 15. Date of referral/transfer from another facility

☐ Date: (DD/MM/YYYY)

☐ Not recorded

Question: WOM_REF_TIMEFROM**Required****Show if:** (WOM_ADM_REFFROM = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

 16. Time of referral/transferred from another facility

- ☐ Time: (HH:MM)
- ☐ Not recorded

Question: WOM_REF_NAMEFROM**Show if:** (WOM_ADM_REFFROM = 1:[Yes])


Scale Summary		
Code	Label	Show-If
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95	Other (specify):	
-1	Not recorded	

 17. Where was the woman referred/transferred from?

- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ 
- ☐ Other (specify):
- ☐ Not recorded

Question: WOM_REF_TYPEFROM**Required****Show if:** (WOM_ADM_REFFROM = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Health Clinic / Health Post / Mobile Unit	
2	Community Hospital	
3	Regional hospital	
995	Other (specify)	
-1	Not recorded	

 18. Type of facility the woman was referred/transferred from

- ☐ Health Clinic / Health Post / Mobile Unit
- ☐ Community Hospital
- ☐ Regional hospital
- ☐ Other (specify)
- ☐ Not recorded

This file is ineligible. You indicated that the date of admission was . Please review records where the birth occurred between 21/09/2015-17/09/2017 or 04/04/2011-31/03/2013.

Jump-To: JMP2**Description:****Jump-To-Item:** END

Jump-If: ((DATE_ELEGIBILITY_2015 = 1) and (DATE_ELEGIBILITY_2017 = 0)) or ((DATE_ELEGIBILITY_2017 = 1) and (DATE_ELEGIBILITY_2015 = 0)) or ((DATE_ELEGIBILITY_2011 = 1) and (DATE_ELEGIBILITY_2013 = 0)) or ((DATE_ELEGIBILITY_2013 = 1) and (DATE_ELEGIBILITY_2011 = 0))

Review the Hospital Admission and Exit Record Sheet. If available, search in the file for the following information about personal data.

19.  

☐ Other (specify):

☐ Not recorded

20. Age:

21. Marital status:

- ☐ Married
- ☐ Single
- ☐ Common law wife
- ☐ Divorced
- ☐ Widowed
- ☐ Other (specify):
- ☐ Not recorded

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	
-1	Not recorded	



22. Read and write:

- ☐ Yes
- ☐ No
- ☐ Not recorded

Question: MRR_ETHNICITY
Required

Scale Summary		
Code	Label	Show-If
1	Creole	
2	East Indian	
3	Garifuna	
4	Chinese/Taiwanese	
5	Mayan (Mopan, Yucatec, Ketchi)	
6	Caucasian	
7	Mestizo	
8	Mennonite	
995	Other (specify)	
-1	Not recorded	



23. Ethnicity:

- ☐ Creole
- ☐ East Indian
- ☐ Garifuna
- ☐ Chinese/Taiwanese
- ☐ Mayan (Mopan, Yucatec, Ketchi)
- ☐ Caucasian
- ☐ Mestizo
- ☐ Mennonite
- ☐ Other (specify)
- ☐ Not recorded

Question: MRR_EDU
Required

Scale Summary		
Code	Label	Show-If
1	None	
2	Primary	
3	Secondary	
5	University	
-1	Not recorded	



24. Education:

- ☐ None
- ☐ Primary
- ☐ Secondary
- ☐ University
- ☐ Not recorded

Question: WOM_SICKLE
Required

Scale Summary		
Code	Label	Show-If
2	AS	
1	SS	
0	Neg	
-1	Not recorded	



25. Sickle Cell status:

- ☐ AS
- ☐ SS
- ☐ Neg
- ☐ Not recorded

Question: WOM_DIST_ID
Required

Scale Summary		
Code	Label	Show-If
2001	Orange Walk	
2002	Corozal District	
2004	Cayo District	
995	Other	
-1	Not recorded	



26. What district is the woman from:

- ☐ Orange Walk
- ☐ Corozal District
- ☐ Cayo District
- ☐ Other
- ☐ Not recorded

Question: WOM_GESTAGE
Required

Scale Summary		
Code	Label	Show-If
1	Age:	
-1	Not recorded	




27. Gestational age:

- ☐ Age: weeks

☐ Not recorded

Question: WOM_BABYCOMPL

Minimum checks: 1

 28. Please note if the child has any of the following complications (select all that apply)

- ☐ Sepsis
☐ Asphyxia
☐ Low birth weight
☐ Prematurity
☐ Other
☐ No complications

Question: WOM_BABYBIRTH_WHERE

Required

Scale Summary		
Code	Label	Show-If
1	In this health facility	
2	In another health facility	
3	In the home	
4	En route to this facility	
5	The birth did not occur	
995	Other (specify):	
-1	Not recorded	

 29. Where did the birth occur?


- ☐ In this health facility
☐ In another health facility
☐ In the home
☐ En route to this facility
☐ The birth did not occur
☐ Other (specify):
☐ Not recorded

Question: WOM_BABYBIRTH_DATE

Required

Show if: (WOM_BABYBIRTH_WHERE ≠ 5:[The birth did not occur])

Scale Summary		
Code	Label	Show-If
1	Yes:	
-1	Not recorded	

 30. Please note if the following was recorded for the baby:

Date of birth:


- ☐ Yes: (DD/MM/YYYY)
☐ Not recorded

Question: WOM_BABYBIRTH_TIME

Required

Show if: (WOM_BABYBIRTH_WHERE ≠ 5:[The birth did not occur])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

 31. Please note if the following was recorded for the baby:

Time of birth

- ☐ Time: (HH:MM)
☐ Not recorded

Jump-To: JUMPTO_END

Description:

Jump-To-Item: END

Jump-If: (MRR_WOM_DEL_COMP is-any-of)

Collection: SEPSIS

Contains: SEP

Show if: (MRR_WOM_DEL_COMP is-any-of)

Please note if the following was done for the patient with sepsis.


Collection: SEP

Contains: WOM_SEP_CAUSE_, WOM_SEP_CAUSE_OTH_SPEC, WOM_SEP_PROCEDURES_, WOM_SEP_PROCEDURES_OTH_SPEC, WOM_SEP_MEDICATIONS, WOM_SEP_SPECIAL_EVER, WOM_SEP_SPECIAL_TYPE, WOM_SEP_CONSULT_SPECIAL_DATE, WOM_SEP_CONSULT_SPECIAL_TIME, WOM_SEP_RESULT, WOM_SEP_DISPOSITION, WOM_SEP_REF_REAS, WOM_SEP_REF_ACCOMTO, WOM_SEP_REF_NAMETO, WOM_SEP_REF_TYPTETO, WOM_SEP_DIS_DATE, WOM_SEP_DIS_TIME, WOM_SEP_DEATH_DATE, WOM_SEP_DEATH_TIME

Show if: (FACILITY_TYPE = 2) or (FACILITY_TYPE = 3)

Review the entire medical record to complete the next section. Please note whether the following checkups were done. Record the value, as well as the date and time of the **first** **checkup** for each item listed below.

Custom Layout Question: WOM_SEP_CHECK

 32.	Recorded Value	Date (DD/MM/YYYY)	Time (HH:MM)
Blood pressure (bp)	<input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
Pulse	<input type="text"/>	<input type="text"/>	<input type="text"/>
Heart rate (hr)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Respiratory rate (rr)	<input type="text"/> per minute	<input type="text"/>	<input type="text"/>
Temperature (T°)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify) <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Review the entire medical record to complete the next section. Please note whether the following lab tests were done. Record the value, as well as the date and time of the **first checkup for each item listed below**.

Custom Layout Question: WOM_SEP_LAB

33.	Recorded Value	Date (DD/MM/YYYY)	Time (HH:MM)
Leukocyte count	<input type="text"/> x10 ³ /liter	<input type="text"/>	<input type="text"/>
Platelet count	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hemoglobin (Hgb or Hb)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hematocrit (Hto or Hct)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>

Question Block: WOM_SEP_CAUSE_

Contains: WOM_SEP_CAUSE_ABORT2, WOM_SEP_CAUSE_PRERUPTURE, WOM_SEP_CAUSE_PERF, WOM_SEP_CAUSE_CORIO, WOM_SEP_CAUSE_ABSCESS, WOM_SEP_CAUSE_PELVICABSCESS, WOM_SEP_CAUSE_ECTINFECT, WOM_SEP_CAUSE_PELVIPER, WOM_SEP_CAUSE_CANALTEAR, WOM_SEP_CAUSE_EPISTOINFECTION, WOM_SEP_CAUSE_POSTENDO, WOM_SEP_CAUSE_FEVER, WOM_SEP_CAUSE_PRODUCT, WOM_SEP_CAUSE_OTH

Required

Code	Label	Show-If
1	Yes	
0	No	

34. Please record the cause of sepsis (select all that apply)

	Yes	No
Septic abortion	<input type="radio"/>	<input type="radio"/>
Septic abortion, corioplacentarios remain infected	<input type="radio"/>	<input type="radio"/>
Premature rupture of membranes (RPM)	<input type="radio"/>	<input type="radio"/>
Uterine perforation	<input type="radio"/>	<input type="radio"/>
Chorioamnionitis	<input type="radio"/>	<input type="radio"/>
Abscesses (in general)	<input type="radio"/>	<input type="radio"/>
Pelvic abscess	<input type="radio"/>	<input type="radio"/>
Infected ectopic pregnancies	<input type="radio"/>	<input type="radio"/>
Pelvipерitonitis	<input type="radio"/>	<input type="radio"/>
Vaginal canal tear	<input type="radio"/>	<input type="radio"/>
Infected episiotomy	<input type="radio"/>	<input type="radio"/>
Postpartum or post-cesarean endometritis	<input type="radio"/>	<input type="radio"/>
Puerperal fever	<input type="radio"/>	<input type="radio"/>
Retained product	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

Question: WOM_SEP_CAUSE_OTH_SPEC

Required

Show if: (WOM_SEP_CAUSE_OTH = 1:[Yes])

49. What is the other cause of sepsis?

Question Block: WOM_SEP_PROCEDURES_

Contains: WOM_SEP_PROCEDURES_AMEU, WOM_SEP_PROCEDURES_CAVIDAD, WOM_SEP_PROCEDURES_LEGRADO, WOM_SEP_PROCEDURES_HIST, WOM_SEP_PROCEDURES_LAP, WOM_SEP_PROCEDURES_SUTURE, WOM_SEP_PROCEDURES_SURG, WOM_SEP_PROCEDURES_DRENAJE, WOM_SEP_PROCEDURES_SALPIN, WOM_SEP_PROCEDURES_OTH

Required

Code	Label	Show-If
1	Yes	
0	No	

50. Please record if any of the following procedures were performed (select all that apply):

	Yes	No
MVA (Manual vacuum aspiration)	<input type="radio"/>	<input type="radio"/>
Revision of uterine cavity	<input type="radio"/>	<input type="radio"/>
Instrumental curettage	<input type="radio"/>	<input type="radio"/>
Hysterectomy	<input type="radio"/>	<input type="radio"/>

Laparotomy	<input type="radio"/>	<input type="radio"/>
Sutures	<input type="radio"/>	<input type="radio"/>
Surgical repair	<input type="radio"/>	<input type="radio"/>
Drainage	<input type="radio"/>	<input type="radio"/>
Salpingectomy	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

Question: WOM_SEP_PROCEDURES_OTH_SPEC

Required

Show if: (WOM_SEP_PROCEDURES_OTH = 1:[Yes])



60. What other procedure was performed?

Review the entire medical record to complete the next section. Please note whether the following medications were administered. Record the dose, as well as the date and time of the **first administration for each medication listed below**.

Custom Layout Question: WOM_SEP_MED



61.

	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Amikacin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Clindamycin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Gentamicin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ampicillin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Metronidazole	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Penicillin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Crystalline Penicillin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Piperacillin	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Tazobactam	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other antibiotic (specify) <input type="text"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other medication (specify) <input type="text"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other medication (specify) <input type="text"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other medication (specify) <input type="text"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Question: WOM_SEP_MEDICATIONS

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	



62. Were any of the above medications administered at the same time during this hospitalization?

- ☐ Yes
☐ No

Question: WOM_SEP_SPECIAL_EVER

Required

Scale Summary		
Code	Label	Show-If
1	Yes, marked with an 'ME' notation in the signature	Never Shown
2	Yes, marked with a stamp	
995	Yes, marked with another method (specify)	
0	No	
-1	Not recorded	



63. Was the woman ever evaluated by a specialist?

- ☐ Yes, marked with an 'ME' notation in the signature
☐ Yes, marked with a stamp
☐ Yes, marked with another method (specify)
☐ No
☐ Not recorded

Question: WOM_SEP_SPECIAL_TYPE**Required**

Show if: (WOM_SEP_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (WOM_SEP_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (WOM_SEP_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Obstetrician	
2	Gynecologist	
3	OBGYN	
4	Surgeon	
995	Other (specify):	
-1	Not recorded	



64. What type of specialist checked the woman?

- ☐ Obstetrician
☐ Gynecologist
☐ OBGYN
☐ Surgeon
☐ Other (specify):
☐ Not recorded

Question: WOM_SEP_CONSULT_SPECIAL_DATE**Required**

Show if: (WOM_SEP_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (WOM_SEP_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (WOM_SEP_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	



65. Date of the first evaluation by the specialist:

- ☐ Date: (DD/MM/YYYY)
☐ Not recorded

Question: WOM_SEP_CONSULT_SPECIAL_TIME**Required**

Show if: (WOM_SEP_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (WOM_SEP_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (WOM_SEP_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Hour:	
-1	Not recorded	



66. Time of the first evaluation by the specialist:

- ☐ Hour: (HH:MM)
☐ Not recorded

Question: WOM_SEP_RESULT**Required**

Scale Summary		
Code	Label	Show-If
1	Vaginal birth	
2	Routine cesarean	
3	Emergency cesarean	
4	Abortion	
995	Otro	
-1	Not recorded	



67. Result of the pregnancy

- ☐ Vaginal birth
☐ Routine cesarean
☐ Emergency cesarean
☐ Abortion
☐ Otro
☐ Not recorded

Question: WOM_SEP_DISPOSITION**Required**

Scale Summary		
Code	Label	Show-If
1	Death in hospital	
2	Discharged home	
3	Transferred/referred to another facility	
4	Left against medical advice	
5	Unknown	
995	Other (specify):	
-1	Not recorded	



68. Disposition:


- ☐ Death in hospital
☐ Discharged home
☐ Transferred/referred to another facility
☐ Left against medical advice

- Question:** WOM_SEP_REF_REAS
Minimum checks: 1
Show if: (WOM_SEP_DISPOSITION = 3:[Transferred/referred to another facility])

☐ High temperature
☐ High leukocyte
☐ Bleeding
☐ Lochia
☐ Other
☐ Not recorded

Question: WOM_SEP_REF_ACCOMTO
Required
Show if: (WOM_SEP_DISPOSITION = 3:[Transferred/referred to another facility])

Scale Summary		
Code	Label	Show-If
1	Yes, by a doctor	
2	Yes, by a nurse	
995	Yes, by another worker	
0	No	
-1	Not recorded	

 70. Was the woman accompanied by a health facility worker?

☐ Yes, by a doctor

☐ Yes, by a nurse

☐ Yes, by another worker

☐ No

☐ Not recorded

Question: WOM_SEP_REF_NAMETO
Show if: (WOM_SEP_DISPOSITION = 3:[Transferred/referred to another facility])

Scale Summary		Show If
Code	Label	
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95	Other (specify):	
-1	Not recorded	

[illegible]

Question: WOM_SEP_REF_TYPETO**Required****Show if:** (WOM_SEP_DISPOSITION = 3:[Transferred/referred to another facility])

Scale Summary		
Code	Label	Show-If
1	Health Clinic / Health Post / Mobile Unit	
2	Community Hospital	
3	Regional hospital	
995	Other (specify)	
-1	Not recorded	

72. Type of facility the woman was transferred to:

- ☐ Health Clinic / Health Post / Mobile Unit
☐ Community Hospital
☐ Regional hospital
☐ Other (specify)
☐ Not recorded

Question: WOM_SEP_DIS_DATE**Required****Show if:** (WOM_SEP_DISPOSITION is-any-of 2:[Discharged home] or 3:[Transferred/referred to another facility] or 4:[Left against medical advice] or 995:[Other (specify):])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

73. Date of discharge/transfer/referral

- ☐ Date: (DD/MM/YYYY)
☐ Not recorded

Question: WOM_SEP_DIS_TIME**Required****Show if:** (WOM_SEP_DISPOSITION is-any-of 2:[Discharged home] or 3:[Transferred/referred to another facility] or 4:[Left against medical advice] or 995:[Other (specify):])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

74. Time of discharge/transfer/referral

- ☐ Time: (HH:MM)
☐ Not recorded

Question: WOM_SEP_DEATH_DATE**Required****Show if:** (WOM_SEP_DISPOSITION = 1:[Death in hospital])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

75. Date of death

- ☐ Date: (DD/MM/YYYY)
☐ Not recorded

Question: WOM_SEP_DEATH_TIME**Required****Show if:** (WOM_SEP_DISPOSITION = 1:[Death in hospital])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

76. Time of death

- ☐ Time: (HH:MM)
☐ Not recorded

Collection: HEMORRHAGE**Contains:** HEM**Show if:** (MRR_WOM_DEL_COMP is-any-of)*Please note whether the following was recorded for patient with hemorrhage.***Collection:** HEM

Contains: WOM_HEM_CAUSE_, WOM_HEM_CAUSE_OTH_SPEC, WOM_HEM_PROCEDURES_, WOM_HEM_REPOSITION_SED, WOM_HEM_REPOSITION_SURG, WOM_HEM_PROCEDURES_OTH_SPEC, WOM_HEM_BLOODLOSS, WOM_HEM_BLOODLOSS_QUAL, WOM_HEM_MEDICATIONS, WOM_HEM_SPECIAL_EVER, WOM_HEM_SPECIAL_TYPE, WOM_HEM_CONSULT_SPECIAL_DATE, WOM_HEM_CONSULT_SPECIAL_TIME, WOM_HEM_RESULT, WOM_HEM_DISPOSITION, WOM_HEM_REF_REASTO, WOM_HEM_REF_ACCOMTO, WOM_HEM_REF_NAMETO, WOM_HEM_REF_TYPETO, WOM_HEM_DIS_DATE, WOM_HEM_DIS_TIME, WOM_HEM_DEATH_DATE, WOM_HEM_DEATH_TIME

Show if: (FACILITY_TYPE = 2) or (FACILITY_TYPE = 3)

Review the entire medical record to complete the next section. Please note whether the following checkups were done. Record the value, as well as the date and time of the **first** **checkup** for each item listed below.

Custom Layout Question: WOM_HEM_CHECK

77.	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Blood pressure (bp)	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
Pulse	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Heart rate (hr)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Respiratory rate (rr)	<input type="checkbox"/>	<input type="text"/> per minute	<input type="text"/>	<input type="text"/>
Temperature (T°)	<input type="checkbox"/>	<input type="text"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
State of consciousness	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Review the entire medical record to complete the next section. Please note whether the following lab tests were done. Record the value, as well as the date and time of the **first checkup for each item listed below**.

Custom Layout Question: WOM_HEM_LAB

78.	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Protrombin time (PT)	<input type="text"/>	<input type="text"/> seconds	<input type="text"/>	<input type="text"/>
Partial thromboplastin time (PTT)	<input type="text"/>	<input type="text"/> seconds	<input type="text"/>	<input type="text"/>
Platelets	<input type="text"/>	<input type="text"/> ×10 ³ /L	<input type="text"/>	<input type="text"/>
Hemoglobin	<input type="text"/>	<input type="text"/> g/dL	<input type="text"/>	<input type="text"/>
Hematocrit	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Question Block: WOM_HEM_CAUSE

Contains: WOM_HEM_CAUSE_ABORT, WOM_HEM_CAUSE_ABORT2, WOM_HEM_CAUSE_ABORT3, WOM_HEM_CAUSE_RETAIN, WOM_HEM_CAUSE_RETAINPART, WOM_HEM_CAUSE_RESTOS, WOM_HEM_CAUSE_PRODUCT, WOM_HEM_CAUSE_PLACENT, WOM_HEM_CAUSE_PREVIA, WOM_HEM_CAUSE_PREVIA2, WOM_HEM_CAUSE_PREMATURE, WOM_HEM_CAUSE_PLACENTA, WOM_HEM_CAUSE RUPTURE, WOM_HEM_CAUSE RUPTUREV, WOM_HEM_CAUSE RUPTUREC, WOM_HEM_CAUSE ATONY, WOM_HEM_CAUSE HIPO, WOM_HEM_CAUSE ECTOPIC, WOM_HEM_CAUSE ECTOPICROTO, WOM_HEM_CAUSE_DESCERV, WOM_HEM_CAUSE_DESCANAL, WOM_HEM_CAUSE_DESVULVO, WOM_HEM_CAUSE_INVERSION, WOM_HEM_CAUSE_OTRO

Required

Code	Label	Show-If
1	Yes	
0	No	

79. Record the reason for hemorrhage (select all that apply)

((PLEASE NOTE ALL OPTIONS APPROPRIATELY ACCORDING TO THE RECORD))

	Yes	No
Complicated abortion (in general)	<input type="radio"/>	<input type="radio"/>
Incomplete abortion complicated with hemorrhage	<input type="radio"/>	<input type="radio"/>
Hemorrhage following the abortion	<input type="radio"/>	<input type="radio"/>
Total retained placenta	<input type="radio"/>	<input type="radio"/>
Partial retained placenta	<input type="radio"/>	<input type="radio"/>
Placental or coroplacental remainders	<input type="radio"/>	<input type="radio"/>
Retained product	<input type="radio"/>	<input type="radio"/>
Placental acretism	<input type="radio"/>	<input type="radio"/>
Placenta previa	<input type="radio"/>	<input type="radio"/>
Placenta previa with hemorrhage	<input type="radio"/>	<input type="radio"/>
Premature placental abruption	<input type="radio"/>	<input type="radio"/>
Placental abruption	<input type="radio"/>	<input type="radio"/>
Uterine rupture	<input type="radio"/>	<input type="radio"/>
Vaginal rupture	<input type="radio"/>	<input type="radio"/>
Cervical rupture	<input type="radio"/>	<input type="radio"/>
Uterine atony	<input type="radio"/>	<input type="radio"/>
Hypotonia	<input type="radio"/>	<input type="radio"/>
Ectopic pregnancy	<input type="radio"/>	<input type="radio"/>
Broken ectopic pregnancy	<input type="radio"/>	<input type="radio"/>
Tears of the cervix	<input type="radio"/>	<input type="radio"/>

Vaginal canal tears	<input type="radio"/>	<input type="radio"/>
Vulvo-perineal tears	<input type="radio"/>	<input type="radio"/>
Uterine inversion	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

Question: WOM_HEM_CAUSE_OTH_SPEC

Required

Show if: (WOM_HEM_CAUSE_OTRO = 1:[Yes])



103. What is the other cause of hemorrhage?

Question Block: WOM_HEM_PROCEDURES_

Contains: WOM_HEM_PROCEDURES_AMEU, WOM_HEM_PROCEDURES_CAVIDAD, WOM_HEM_PROCEDURES_LEGRADO, WOM_HEM_PROCEDURES_CSEC, WOM_HEM_PROCEDURES_HIST, WOM_HEM_PROCEDURES_LAP, WOM_HEM_PROCEDURES_BLYNCH, WOM_HEM_PROCEDURES_SUTURE2, WOM_HEM_PROCEDURES_SUTURE, WOM_HEM_PROCEDURES_SURG, WOM_HEM_PROCEDURES_DRENAJE, WOM_HEM_PROCEDURES_SALPIN, WOM_HEM_PROCEDURES_MASAJE, WOM_HEM_PROCEDURES_BIMAN, WOM_HEM_PROCEDURES_AORTA, WOM_HEM_PROCEDURES_TAP, WOM_HEM_PROCEDURES_BALON, WOM_HEM_PROCEDURES_MANUAL, WOM_HEM_PROCEDURES_REP, WOM_HEM_PROCEDURES_HYOART, WOM_HEM_PROCEDURES_UTART, WOM_HEM_PROCEDURES_OTH

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	



104. Record if the following procedures were performed (select all that apply)

((PLEASE NOTE ALL OPTIONS APPROPRIATELY ACCORDING TO THE RECORD))

	Yes	No
Manual vacuum aspiration (MVA)	<input type="radio"/>	<input type="radio"/>
Revision of uterine cavity	<input type="radio"/>	<input type="radio"/>
Instrumental curettage	<input type="radio"/>	<input type="radio"/>
Caesarean	<input type="radio"/>	<input type="radio"/>
Hysterectomy	<input type="radio"/>	<input type="radio"/>
Laparotomy	<input type="radio"/>	<input type="radio"/>
B-lynch suture	<input type="radio"/>	<input type="radio"/>
Compression sutures	<input type="radio"/>	<input type="radio"/>
Sutures	<input type="radio"/>	<input type="radio"/>
Surgical repair	<input type="radio"/>	<input type="radio"/>
Drainage	<input type="radio"/>	<input type="radio"/>
Salpinguectomy	<input type="radio"/>	<input type="radio"/>
Uterine massage	<input type="radio"/>	<input type="radio"/>
Bimanual Compression	<input type="radio"/>	<input type="radio"/>
Compression of the aorta	<input type="radio"/>	<input type="radio"/>
Uterine tamponade	<input type="radio"/>	<input type="radio"/>
Hydrostatic balloon	<input type="radio"/>	<input type="radio"/>
Manual Extraction (of the placenta)	<input type="radio"/>	<input type="radio"/>
Repositioning of the uterus with non-surgical techniques (such as Johnson's maneuver) or surgical techniques (such as Huntington or Haultani maneuvers)	<input type="radio"/>	<input type="radio"/>
Hypogastric artery ligation	<input type="radio"/>	<input type="radio"/>
Uterine artery ligation	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

Question: WOM_HEM_REPOSITION_SED

Required

Show if: (WOM_HEM_PROCEDURES_REP = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Yes, with analgesics	
2	Yes, with sedation	
3	Yes, with anesthesia	
0	No	
-1	Not recorded	



126. Did you give anesthesia or sedatives to the woman during the repositioning of the uterus?

- ☐ Yes, with analgesics
☐ Yes, with sedation

- ☐ Yes, with anesthesia
☐ No
☐ Not recorded

Question: WOM_HEM_REPOSITION_SURG

Required

Show if: (WOM_HEM_PROCEDURES_REP = 1:[Yes])

Scale Summary		
Code	Label	Show-If
1	Non-surgical technique (specify)	
2	Surgical technique (specify)	
-1	Not recorded	

127. What technique was used to reposition the uterus?

- ☐ Non-surgical technique (specify)
☐ Surgical technique (specify)
☐ Not recorded

Question: WOM_HEM_PROCEDURES_OTH_SPEC

Required

Show if: (WOM_HEM_PROCEDURES_OTH = 1:[Yes])

128. What other procedure was performed?

Question: WOM_HEM_BLOODLOSS

Required

Scale Summary		
Code	Label	Show-If
1	Amount of blood:	
-1	Not recorded	

129. How much blood did the woman lose during the complication?

- ☐ Amount of blood:
☐ Not recorded

Question: WOM_HEM_BLOODLOSS_QUAL

Required

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	

130. Is there any qualitative assessment of the amount of blood lost?

- ☐ Yes
☐ No

Review the entire medical record to complete the next section. Please note whether the following medications were administered. Record the dose, as well as the date and time of the **first administration for each medication listed below**.

Custom Layout Question: WOM_HEM_MED

131.

	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Oxytocin	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ringer's lactate	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hartmann's solution	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Saline solution	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Gentamicin	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Misoprostol	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Metilergonovine	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other uterotonic (specify) <input type="text"/>	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other medication (specify) <input type="text"/>	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other medication (specify) <input type="text"/>	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other medication (specify) <input type="text"/>	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Question: WOM_HEM_MEDICATIONS

Required

Scale Summary		
Code	Label	Show-If
1	Yes	

0 No

132. Were any of the above medications administered at the same time during this hospitalization?

- ☐ Yes
☐ No

Question: WOM_HEM_SPECIAL_EVER

Required

Scale Summary		
Code	Label	Show-If
1	Yes, marked with an 'ME' notation in the signature	Never Shown
2	Yes, marked with a stamp	
995	Yes, marked with another method (specify)	
0	No	
-1	Not recorded	

133. Was the woman ever checked by a specialist?

- ☐ Yes, marked with an 'ME' notation in the signature
☐ Yes, marked with a stamp
☐ Yes, marked with another method (specify)
☐ No
☐ Not recorded

Question: WOM_HEM_SPECIAL_TYPE

Required

Show If: (WOM_HEM_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (WOM_HEM_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (WOM_HEM_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Obstetrician	
2	Gynecologist	
3	OBGYN	
4	Surgeon	
995	Other (specify):	
-1	Not recorded	

134. What type of specialist checked the woman?

- ☐ Obstetrician
☐ Gynecologist
☐ OBGYN
☐ Surgeon
☐ Other (specify):
☐ Not recorded

Question: WOM_HEM_CONSULT_SPECIAL_DATE

Required

Show If: (WOM_HEM_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (WOM_HEM_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (WOM_HEM_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

135. Date of the first evaluation by the specialist:

- ☐ Date: (DD/MM/YYYY)
☐ Not recorded

Question: WOM_HEM_CONSULT_SPECIAL_TIME

Required

Show If: (WOM_HEM_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (WOM_HEM_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (WOM_HEM_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Hour:	
-1	Not recorded	

136. Time of the first evaluation by the specialist:

- ☐ Hour: (HH:MM)
☐ Not recorded

Question: WOM_HEM_RESULT

Required

Scale Summary		
Code	Label	Show-If
1	Vaginal birth	
2	Routine cesarean	
3	Emergency cesarean	
4	Abortion	
995	Other	
-1	Not recorded	

137. Result of the pregnancy:

- ☐ Vaginal birth
☐ Routine cesarean
☐ Emergency cesarean
☐ Abortion
☐ Other
☐ Not recorded

Question: WOM_HEM_DISPOSITION

Required

138. Disposition:

- ☐ Death in hospital
- ☐ Discharged home
- ☐ Transferred/referred to another facility
- ☐ Left against medical advice
- ☐ Unknown
- ☐ Other (specify):
- ☐ Not recorded

139. Reason for transfer/referral:

- ☐ Low blood pressure
- ☐ Low hemoglobin
- ☐ Bleeding
- ☐ Lochia
- ☐ Other
- ☐ Not recorded

Scale Summary		
Code	Label	Show-If
1	Yes, by a doctor	
2	Yes, by a nurse	
995	Yes, by another worker	
0	No	
-1	Not recorded	

140. Was the woman accompanied by a health facility worker?

☐ Yes, by a doctor

☐ Yes, by a nurse










☐ Yes, by another worker

☐ No

☐ Not recorded

Scale Summary		Show-If
Code	Label	
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95	Other (specify):	
-1	Not recorded	

[illegible]


- ☐ 
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☐ Other (specify):
☐ Not recorded

Question: WOM_HEM_REF_TYPETO

Required

Show if: (WOM_HEM_DISPOSITION = 3:[Transferred/referred to another facility])

Scale Summary		
Code	Label	Show-If
1	Health Clinic / Health Post / Mobile Unit	
2	Community Hospital	
3	Regional hospital	
995	Other (specify)	
-1	Not recorded	

 142. Type of facility the woman was transferred/referred to:


- ☐ Health Clinic / Health Post / Mobile Unit
☐ Community Hospital
☐ Regional hospital
☐ Other (specify)
☐ Not recorded

Question: WOM_HEM_DIS_DATE

Required

Show if: (WOM_HEM_DISPOSITION is-any-of 2:[Discharged home] or 3:[Transferred/referred to another facility] or 4:[Left against medical advice] or 995:[Other (specify):])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

 143. Date of discharge/transfer/referral


- ☐ Date: (DD/MM/YYYY)
☐ Not recorded

Question: WOM_HEM_DIS_TIME

Required

Show if: (WOM_HEM_DISPOSITION is-any-of 2:[Discharged home] or 3:[Transferred/referred to another facility] or 4:[Left against medical advice] or 995:[Other (specify):])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

 144. Time of discharge/transfer/referral


- ☐ Time: (HH:MM)
☐ Not recorded

Question: WOM_HEM_DEATH_DATE

Required

Show if: (WOM_HEM_DISPOSITION = 1:[Death in hospital])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

 145. Date of death:

- ☐ Date: (DD/MM/YYYY)
☐ Not recorded

Question: WOM_HEM_DEATH_TIME

Required

Show if: (WOM_HEM_DISPOSITION = 1:[Death in hospital])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

 146. Time of death

- ☐ Time: (HH:MM)
☐ Not recorded

Collection: PRE-ECLAMPSIA

Contains: PRE_

Show if: (MRR_WOM_DEL_COMP is-any-of)

Please note whether the following was recorded for patient with pre-eclampsia.

Collection: PRE_

Contains: WOM_PRE_MEDICATIONS, WOM_PRE_SPECIAL_EVER, WOM_PRE_SPECIAL_TYPE, WOM_PRE_CONSULT_SPECIAL_DATE, WOM_PRE_CONSULT_SPECIAL_TIME, WOM_PRE_RESULT, WOM_PRE_DISPOSITION, WOM_PRE_REF_REASTO, WOM_PRE_REF_ACCOMTO, WOM_PRE_REF_NAMETO, WOM_PRE_REF_TYPETO, WOM_PRE_DIS_DATE, WOM_PRE_DIS_TIME, WOM_PRE_DEATH_DATE, WOM_PRE_DEATH_TIME

Show if: (FACILITY_TYPE = 2) or (FACILITY_TYPE = 3)

Review the entire medical record to complete the next section. Please note whether the following checkups were done. Record the value, as well as the date and time of the **first** **checkup for each item listed below**.

Custom Layout Question: WOM_PRE_CHECK1

147.	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Blood pressure (bp)	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
Patellar reflex	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pulse	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Heart rate (hr)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Respiratory rate (rr)	<input type="checkbox"/>	<input type="text"/> per minute	<input type="text"/>	<input type="text"/>
Temperature (T°)	<input type="checkbox"/>	<input type="text"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Review the entire medical record to complete the next section. Please note whether the following checkups were done. Record the date and time of the **first checkup for each item listed below.**

Custom Layout Question: WOM_PRE_CHECK2

148.	Recorded (yes/no)	Date (DD/MM/YYYY)	Time (HH:MM)
Seizures	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Reflexes	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Oliguria	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Review the entire medical record to complete the next section. Please note whether the following lab tests were done. Record the value, as well as the date and time of the **first checkup for each item listed below.**

Custom Layout Question: WOM_PRE_LAB1

149.	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Platelet count	<input type="checkbox"/>	<input type="text"/> x10 ³ /L	<input type="text"/>	<input type="text"/>
Aspartate aminotransferase	<input type="checkbox"/>	<input type="text"/> U/liter	<input type="text"/>	<input type="text"/>
Alanine aminotransferase	<input type="checkbox"/>	<input type="text"/> U/liter	<input type="text"/>	<input type="text"/>
Lactate dehydrogenase	<input type="checkbox"/>	<input type="text"/> U/liter	<input type="text"/>	<input type="text"/>
Creatinine	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Uric acid	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Glutamic-oxalacetic transaminase (TGO or GOT)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Glutamic-pyruvate transaminase (TGP or GPT)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Review the entire medical record to complete the next section. Please note whether the following lab tests were done. Record the values, as well as the date and time of the **first checkup for each item listed below.**

Custom Layout Question: WOM_PRE_LAB2

150.	Recorded (yes/no)	Negative	Number of +	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Urine protein	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/> g/day	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Review the entire medical record to complete the next section. Please note whether the following medications were administered. Record the dose, as well as the date and time of the **first administration for each medication listed below.**

Custom Layout Question: WOM_PRE_MED

151.	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Magnesium sulfate (zuspam, SMg4)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hidralazine	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Nifedipine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Betamethasone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Dexamethasone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Saline solution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Ringer's lactate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Hartmann's solution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Labetalol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other antihypertensive (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other medication (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other medication (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other medication (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Question: WOM_PRE_MEDICATIONS**Required**

Scale Summary		
Code	Label	Show-If
1	Yes	
0	No	



152. Were any of the above medications administered at the same time during this hospitalization?

- ☐ Yes
- ☐ No

Question: WOM_PRE_SPECIAL_EVER**Required**

Scale Summary		
Code	Label	Show-If
1	Yes, marked with an 'ME' notation in the signature	Never Shown
2	Yes, marked with a stamp	
995	Yes, marked with another method (specify)	
0	No	
-1	Not recorded	



153. Was the woman ever checked by a specialist?

- ☐ Yes, marked with an 'ME' notation in the signature
- ☐ Yes, marked with a stamp
- ☐ Yes, marked with another method (specify)
- ☐ No
- ☐ Not recorded

Question: WOM_PRE_SPECIAL_TYPE**Required****Show if:** (WOM_PRE_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (WOM_PRE_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (WOM_PRE_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Obstetrician	
2	Gynecologist	
3	OBGYN	
4	Surgeon	
995	Other (specify):	
-1	Not recorded	



154. What type of specialist checked the woman?

- ☐ Obstetrician
- ☐ Gynecologist
- ☐ OBGYN
- ☐ Surgeon
- ☐ Other (specify):
- ☐ Not recorded

Question: WOM_PRE_CONSULT_SPECIAL_DATE**Required****Show if:** (WOM_PRE_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (WOM_PRE_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (WOM_PRE_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	



155. Date of the first evaluation by the specialist:

- ☐ Date: (DD/MM/YYYY)


☐ Not recorded

Question: WOM_PRE_CONSULT_SPECIAL_TIME

Required

Show if: (WOM_PRE_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (WOM_PRE_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (WOM_PRE_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Hour:	
-1	Not recorded	


 156. Time of the first evaluation by the specialist:

- ☐ Hour: (HH:MM)
- ☐ Not recorded

Question: WOM_PRE_RESULT

Required

Scale Summary		
Code	Label	Show-If
1	Caesarean	
2	Vaginal birth	
995	Other (specify)	
-1	Not recorded	


 157. Result of the pregnancy:

- ☐ Caesarean
- ☐ Vaginal birth
- ☐ Other (specify)
- ☐ Not recorded

Question: WOM_PRE_DISPOSITION

Required

Scale Summary		
Code	Label	Show-If
1	Death in hospital	
2	Discharged home	
3	Transferred/referred to another facility	
4	Left against medical advice	
5	Unknown	
995	Other (specify)	
-1	Not recorded	


 158. Disposition

- ☐ Death in hospital
- ☐ Discharged home
- ☐ Transferred/referred to another facility
- ☐ Left against medical advice
- ☐ Unknown
- ☐ Other (specify)
- ☐ Not recorded

Question: WOM_PRE_REF_REASTO

Minimum checks: 1

Show if: (WOM_PRE_DISPOSITION = 3:[Transferred/referred to another facility])

 159. Reason for transfer/referral


- ☐ High blood pressure
- ☐ Urine protein
- ☐ Bleeding
- ☐ Lochia
- ☐ Seizures
- ☐ Other (specify)
- ☐ Not recorded

Question: WOM_PRE_REF_ACCOMTO

Required

Show if: (WOM_PRE_DISPOSITION = 3:[Transferred/referred to another facility])

Scale Summary		
Code	Label	Show-If
1	Yes, by a doctor	
2	Yes, by a nurse	
995	Yes, by another worker	
0	No	
-1	Not recorded	

 160. Was the woman accompanied by a health facility worker?

- ☐ Yes, by a doctor
- ☐ Yes, by a nurse
- ☐ Yes, by another worker
- ☐ No
- ☐ Not recorded

Question: WOM_PRE_REF_NAMETO

Show if: (WOM_PRE_DISPOSITION = 3:[Transferred/referred to another facility])

Scale Summary		
Code	Label	Show-If
1		
2		
995		
0		
-1		



Reason	Percentage
Other (specify):	1%
Not recorded	1%
Reason 1	1%
Reason 2	1%
Reason 3	1%
Reason 4	1%
Reason 5	1%
Reason 6	1%
Reason 7	1%
Reason 8	1%
Reason 9	1%
Reason 10	1%
Reason 11	1%
Reason 12	1%
Reason 13	1%
Reason 14	1%
Reason 15	1%
Reason 16	1%
Reason 17	1%
Reason 18	1%

☐ Not recorded

Scale Summary		
Code	Label	Show-If
1	Health Clinic / Health Post / Mobile Unit	
2	Community Hospital	
3	Regional hospital	
995	Other (specify)	
-1	Not recorded	

☐ Health Clinic / Health Post / Mobile Unit
☐ Community Hospital
☐ Regional hospital
☐ Other (specify)
☐ Not recorded

☐ Not recorded

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	



☐ Date: (DD/MM/YYYY)

☐ Not recorded

☐ Not recorded

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

☐ Time: (HH:MM)

☐ Not recorded

Question: WOM_PRE_DEATH_DATE**Required****Show if:** (WOM_PRE_DISPOSITION = 1:[Death in hospital])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

165. Date of death:

- ☐ Date: (DD/MM/YYYY)
☐ Not recorded

Question: WOM_PRE_DEATH_TIME**Required****Show if:** (WOM_PRE_DISPOSITION = 1:[Death in hospital])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

166. Time of death:

- ☐ Time: (HH:MM)
☐ Not recorded

Collection: ECLAMPSIA**Contains:** ECL**Show if:** (MRR_WOM_DEL_COMP is-any-of)*Please note whether the following was recorded for patient with eclampsia.***Collection:** ECL
Contains: WOM_ECL_MEDICATIONS, WOM_ECL_SPECIAL_EVER, WOM_ECL_SPECIAL_TYPE, WOM_ECL_CONSULT_SPECIAL_DATE, WOM_ECL_CONSULT_SPECIAL_TIME, WOM_ECL_RESULT, WOM_ECL_DISPOSITION, WOM_ECL_REF_REASTO, WOM_ECL_REF_ACCOMTO, WOM_ECL_REF_NAMETO, WOM_ECL_REF_TYPTETO, WOM_ECL_DIS_DATE, WOM_ECL_DIS_TIME, WOM_ECL_DEATH_DATE, WOM_ECL_DEATH_TIME
Show if: (FACILITY_TYPE = 3) or (FACILITY_TYPE = 2)
 Review the entire medical record to complete the next section. Please note whether the following checkups were done. Record the value, as well as the date and time of the **first checkup for each item listed below**.
Custom Layout Question: WOM_ECL_CHECK1

167.

	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Blood pressure (bp)	<input type="checkbox"/>	<input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
Pulse	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Heart rate (hr)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Respiratory rate (rr)	<input type="checkbox"/>	<input type="text"/> per minute	<input type="text"/>	<input type="text"/>
Temperature (T°)	<input type="checkbox"/>	<input type="text"/> <input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Patellar reflex	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

 Review the entire medical record to complete the next section. Please note whether the following checkups were done. Record the date and time of the **first checkup for each item listed below**.
Custom Layout Question: WOM_ECL_CHECK2

168.

	Recorded (yes/no)	Date (DD/MM/YYYY)	Time (HH:MM)
Seizures	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Reflexes	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Oliguria	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

 Review the entire medical record to complete the next section. Please note whether the following lab tests were done. Record the value, as well as the date and time of the **first checkup for each item listed below**.
Custom Layout Question: WOM_ECL_LAB1

169.

	Recorded (yes/no)	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Platelet count	<input type="checkbox"/>	<input type="text"/> x10 ³ /L	<input type="text"/>	<input type="text"/>
Aspartate aminotransferase	<input type="checkbox"/>	<input type="text"/> U/liter	<input type="text"/>	<input type="text"/>
Alanine aminotransferase	<input type="checkbox"/>	<input type="text"/> U/liter	<input type="text"/>	<input type="text"/>
Lactate dehydrogenase	<input type="checkbox"/>	<input type="text"/> U/liter	<input type="text"/>	<input type="text"/>
Creatinine	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Uric acid	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Glutamic-oxalacetic transaminase (TGO or GOT)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Glutamic-pyruvate transaminase (TGP or GPT)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Review the entire medical record to complete the next section. Please note whether the following lab tests were done. Record the values, as well as the date and time of the **first** **checkup** for each item listed below.

Custom Layout Question: WOM_ECL_LAB2

170.	Recorded (yes/no)	Negative	Number of +	Value	Date (DD/MM/YYYY)	Time (HH:MM)
Urine protein	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Review the entire medical record to complete the next section. Please note whether the following medications were administered. Record the dose, as well as the date and time of the **first** **administration** for each medication listed below.

Custom Layout Question: WOM_ECL_MED

171.	Administered (yes/no)	Dose	Date (DD/MM/YYYY)	Time (HH:MM)
Magnesium sulfate (zuspam, SMg4)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hydralazine	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Nifedipine	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Betamethasone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dexamethasone	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Saline solution	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ringer's lactate	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hartmann's solution	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Labetalol	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other antihypertensive (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other medication (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other medication (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other medication (specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Question: WOM_ECL_MEDICATIONS
Required

Code	Label	Show-If
1	Yes	
0	No	

172. Were any of the above medications administered at the same time during this hospitalization?

- ☐ Yes
☐ No

Question: WOM_ECL_SPECIAL_EVER
Required

Code	Label	Show-If
1	Yes, marked with an 'ME' notation in the signature	Never Shown
2	Yes, marked with a stamp	
995	Yes, marked with another method (specify)	
0	No	
-1	Not recorded	

173. Was the woman ever checked by a specialist?

- ☐ Yes, marked with an 'ME' notation in the signature
☐ Yes, marked with a stamp
☐ Yes, marked with another method (specify)
☐ No

☐ Not recorded

Question: WOM_ECL_SPECIAL_TYPE

Required

Show if: (WOM_ECL_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (WOM_ECL_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (WOM_ECL_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Obstetrician	
2	Gynecologist	
3	OBGYN	
4	Surgeon	
995	Other (specify):	
-1	Not recorded	



174. What type of specialist checked the woman?

- ☐ Obstetrician
☐ Gynecologist
☐ OBGYN
☐ Surgeon
☐ Other (specify):
☐ Not recorded

Question: WOM_ECL_CONSULT_SPECIAL_DATE

Required

Show if: (WOM_ECL_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (WOM_ECL_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (WOM_ECL_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	



175. Date of the first evaluation by the specialist:

- ☐ Date: (DD/MM/YYYY)
☐ Not recorded

Question: WOM_ECL_CONSULT_SPECIAL_TIME

Required

Show if: (WOM_ECL_SPECIAL_EVER = 1:[Yes, marked with an 'ME' notation in the signature]) or (WOM_ECL_SPECIAL_EVER = 2:[Yes, marked with a stamp]) or (WOM_ECL_SPECIAL_EVER = 995:[Yes, marked with another method (specify)])

Scale Summary		
Code	Label	Show-If
1	Hour:	
-1	Not recorded	



176. Time of the first evaluation by the specialist:

- ☐ Hour: (HH:MM)
☐ Not recorded

Question: WOM_ECL_RESULT

Required

Scale Summary		
Code	Label	Show-If
1	Caesarean	
2	Vaginal birth	
995	Other	
-1	Not recorded	



177. Result of the pregnancy:

- ☐ Caesarean
☐ Vaginal birth
☐ Other:
☐ Not recorded

Question: WOM_ECL_DISPOSITION

Required

Scale Summary		
Code	Label	Show-If
1	Death in hospital	
2	Discharged home	
3	Transferred/referred to another facility	
4	Left against medical advice	
5	Unknown	
995	Other (specify):	
-1	Not recorded	



178. Disposition:

- ☐ Death in hospital
☐ Discharged home
☐ Transferred/referred to another facility
☐ Left against medical advice
☐ Unknown
☐ Other (specify):
☐ Not recorded

Question: WOM_ECL_REF_REASTO

Minimum checks: 1

Show if: (WOM_ECL_DISPOSITION = 3:[Transferred/referred to another facility])



179. Reason for transfer/referral

- ☐ High blood pressure

- | Code | Label | Show-If |
|------|------------------------|---------|
| 1 | Yes, by a doctor | |
| 2 | Yes, by a nurse | |
| 995 | Yes, by another worker | |
| 0 | No | |
| -1 | Not recorded | |

☐ Not recorded

Code	Label	Score Summary	Show If
1			
2			
3			
4			
5			
6			
7			
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95	Other (specify):		
-1	Not recorded		

☐ Not recorded

Scale summary		
Code	Label	Show-If
1	Health Clinic / Health Post / Mobile Unit	
2	Community Hospital	
3	Regional hospital	
995	Other (specify)	
-1	Not recorded	

 182. Type of facility the woman was transferred/referred to:


- ☐ Health Clinic / Health Post / Mobile Unit
☐ Community Hospital
☐ Regional hospital
☐ Other (specify)
☐ Not recorded

Question: WOM_ECL_DIS_DATE

Required

Show if: (WOM_ECL_DISPOSITION is-any-of 2:[Discharged home] or 3:[Transferred/referred to another facility] or 4:[Left against medical advice] or 995:[Other (specify):])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

 183. Date of discharge/transfer/referral

- ☐ Date: (DD/MM/YYYY)
☐ Not recorded

Question: WOM_ECL_DIS_TIME

Required

Show if: (WOM_ECL_DISPOSITION is-any-of 2:[Discharged home] or 3:[Transferred/referred to another facility] or 4:[Left against medical advice] or 995:[Other (specify):])

Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

 184. Time of discharge/transfer/referral


- ☐ Time: (HH:MM)
☐ Not recorded

Question: WOM_ECL_DEATH_DATE

Required

Show if: (WOM_ECL_DISPOSITION = 1:[Death in hospital])

Scale Summary		
Code	Label	Show-If
1	Date:	
-1	Not recorded	

 185. Date of death

- ☐ Date: (DD/MM/YYYY)
☐ Not recorded

Question: WOM_ECL_DEATH_TIME

Required

Show if: (WOM_ECL_DISPOSITION = 1:[Death in hospital])


Scale Summary		
Code	Label	Show-If
1	Time:	
-1	Not recorded	

 186. Time of death

- ☐ Time: (HH:MM)
☐ Not recorded

You indicated that the women did not have any complications. Please review only records of sepsis, hemorrhage, pre-eclampsia and eclampsia.

Question: COMMENT_COMPL_MATERNA

 187. Enter relevant comments about this section

You have reached the end of the survey.

Please click the button 'submit' to submit your responses and close the survey. You cannot modify any responses after the survey has been submitted.

If you believe that this page was reached in error, please click 'Previous' and revise your responses as necessary.

Thank you for your time today.