

AMNIOTIC FLUID EMBOLISM

SURVIVOR CLINICAL SUMMARY



This document is intended to summarize the most significant aspects of treatment to aid in patient and family understanding, continuity of care, and to minimize the triggers associated with retelling the event.

PATIENT NAME _____		PHONE _____	DATE OF EVENT _____
PRIMARY CLINICIAN(S) _____			
AFE SYMPTOMS <input type="checkbox"/> Acute Hypotension <input type="checkbox"/> DIC <input type="checkbox"/> Cardiac Arrest		OTHER COMPLICATIONS <input type="checkbox"/> Pulmonary/Saddle Embolus <input type="checkbox"/> Stroke <input type="checkbox"/> Renal Failure <input type="checkbox"/> Other: _____	

DELIVERY INFORMATION

PREGNANCY OUTCOME <input type="checkbox"/> Live Birth <input type="checkbox"/> Still Birth/Fetal Demise		NICU ADMISSION <input type="checkbox"/> Yes # of days _____ Reason _____		
TYPE OF DELIVERY <input type="checkbox"/> Vaginal <input type="checkbox"/> Vacuum <input type="checkbox"/> C-Section <input type="checkbox"/> VBAC <input type="checkbox"/> Forceps <input type="checkbox"/> Emer. C-S		GA (IN WEEKS) _____	WEIGHT & LENGTH _____	TIME OF BIRTH(S) _____

CLINICAL SUMMARY

HYSTERECTOMY DATE _____ TYPE <input type="checkbox"/> Supracervical <input type="checkbox"/> Total <i>*THIS PATIENT SHOULD NOT BE ASKED ABOUT THE LAST MENSTRUAL PERIOD (LMP)</i>		SURGERIES / INTERVENTIONAL RADIOLOGY DATE _____ TYPE _____ RESULTS _____		SURGERIES / INTERVENTIONAL RADIOLOGY DATE _____ TYPE _____ RESULTS _____	
IMAGING TESTS <input type="checkbox"/> X-Ray DATE _____ RESULTS _____ <input type="checkbox"/> MRI DATE _____ RESULTS _____ <input type="checkbox"/> CT DATE _____ RESULTS _____					
BLOOD TRANSFUSIONS: TYPE OF BLOOD PRODUCTS + NUMBER OF UNITS <input type="checkbox"/> Packed Red Blood Cells (PRBC) _____ <input type="checkbox"/> Plasma _____ <input type="checkbox"/> Platelets _____ <input type="checkbox"/> Cryoprecipitate _____					
MEDICATIONS AT DISCHARGE NAME _____ DOSAGE _____ FREQUENCY _____ NAME _____ DOSAGE _____ FREQUENCY _____					

ECHO	RESULTS		EJECTION FRACTION		NEED FOLLOW UP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	RESULTS				NEED FOLLOW UP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
EKG	RESULTS				NEED FOLLOW UP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
EEG	RESULTS				NEED FOLLOW UP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
ECMO	<input type="checkbox"/> VA <input type="checkbox"/> W	LENGTH OF TIME		NEED FOLLOW UP? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	EVALUATION / ASSESMENT				NEED FOLLOW UP? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DIAL PT/OT	TYPE <input type="checkbox"/> Hemo <input type="checkbox"/> APD <input type="checkbox"/> CAPD		FISTULA <input type="checkbox"/> Yes <input type="checkbox"/> No	START DATE	END DATE	NEED FOLLOW UP? <input type="checkbox"/> Yes <input type="checkbox"/> No

MENTAL HEALTH

* Women who suffer an AFE are at risk for postpartum mood and anxiety disorders (PMAD).
 **Those with a history of mental health or mood disorders are at greater risk of PMAD.

HISTORY OF MENTAL HEALTH OR MOOD DISORDERS?

No Yes, list: _____

TREATED IN HOSPITAL?

No Yes

CURRENT PSYCHIATRIC MEDICATION(S)

NAME _____ DOSAGE _____ FREQUENCY _____

CURRENTLY RECEIVING TREATMENT?

No Yes

NAME _____ DOSAGE _____ FREQUENCY _____

PRESCRIBING CLINICIAN NAME _____ PHONE _____

CONTACT INFORMATION

OB CLINICIAN

NAME _____ PHONE _____

ICU CLINICIAN

NAME _____ PHONE _____

MATERNAL FETAL MEDICINE

NAME _____ PHONE _____

NEUROLOGIST

NAME _____ PHONE _____

CARDIOLOGIST

NAME _____ PHONE _____

NEPHROLOGIST

NAME _____ PHONE _____

SOCIAL WORKER

NAME _____ PHONE _____

MEDICAL RECORDS

_____ PHONE _____

ADDITIONAL NOTES