Description

On the night of January 22, 2003, in Concord, New Hampshire, Sarah Wright and her pregnant daughter Vivienne Wright were at their home watching television when Vivienne suddenly started having convulsions. Sarah immediately called 9-1-1 and the paramedics arrived at the home. They found Vivienne in respiratory failure. Vivienne was rushed to the hospital. When they arrived, a group of emergency room staff, including Vivienne's obstetrician, were unable to resuscitate Vivienne and pronounced her dead at 2100. Vivienne's obstetrician accessed her EHR which was populated with Vivienne's basic identifying information including her name, birth date, sex, address, zip code, and social security number. Vivienne had been treated for preeclampsia during her pregnancy and this seemed the most likely cause of death; however her doctor indicated that he wanted an autopsy to be performed and added a referral note. The pathologist/medical examiner, performed an autopsy on January 23rd. He noted in the EHR that Vivienne was pregnant at the time of her death. He noted pulmonary edema and other blood protein and urine results that pointed to eclampsia as the underlying cause of death, although he listed "Cardiopulmonary arrest" as the immediate cause and entered the duration.
He listed "Eclampsia" as the underlying cause of death with a separate duration. He entered his identifying information as the death certifier, signed the death certificate and indicated that the autopsy results were available. At that point, all information related to filing the death certificate is transmitted via an ADT^A04 message from the EHR to the jurisdictional vital records office.

Comments

No Comments

Pre-condition

No PreCondition

Post-Condition

No PostCondition

Test Objectives

The message must provide: Patient demographic information in the PID segment to provide basic demographics to allow identification of the person and matching of the record with information from the funeral director as well as death reporting observations in the OBX Observation/Result segments and further information on the patient death and possible autopsy in the PDA segment. The test case provides an example of relevant elements of recording the death of a patient, and of collecting the information needed to support filing a death certificate.

Support for Date/Time of Birth

Support for Death Location
Support for Autopsy Indicator
Support for Coroner Indicator
Support for Observation Value
Support for Death Certificate Signed Date/Time

Support for Death Certified By
Support for Coroner - Medical Examiner Case Number
Support for Did death involve any injury of any kind
Support for Did Tobacco use contribute to death
Support for Disease onset to death interval
Support for Part\Line Number
Support for Referral Note

Evaluation Criteria
No evaluation criteria

Notes
No Note