

Canadian COVID-19 in Pregnancy Surveillance: Epidemiology, Maternal and Infant Outcomes

SOURCE OF REPORTING	
Site completing DCF:	
Name of individual(s) completing forms:	Email for follow-up reminder:
Date case report forms completed (dd.mmm.yyyy): _____	
General Comments:	

MATERNAL DEMOGRAPHICS

1. Has the patient signed an informed consent? no- research ethics waiver of consent yes, Date: _____
2. Maternal age at estimated date of delivery (EDD): _____ unknown
3. Ethnicity - maternal:
- | | | |
|----------|--------------------------|---|
| | <input type="checkbox"/> | White / Caucasian |
| | <input type="checkbox"/> | African / Caribbean / Black |
| please | <input type="checkbox"/> | Hispanic / Latino |
| select ↗ | <input type="checkbox"/> | East Asian |
| | <input type="checkbox"/> | South Asian |
| all → | <input type="checkbox"/> | South East Asian |
| | <input type="checkbox"/> | West Central Asian / Middle Eastern |
| that ↘ | <input type="checkbox"/> | Indigenous / Aboriginal / First Nations / Métis / Inuit |
| | <input type="checkbox"/> | Other (specify ethnicities of parents) _____ |
| apply | <input type="checkbox"/> | Unknown _____ |
4. Maternal country of birth _____ unknown
5. Employment status during pregnancy:
- Employed
- Unemployed
- Unknown
6. Current occupation: _____ unknown
7. Kind of business, industry or service?: _____ unknown
8. No. of school years completed - maternal: _____ unknown
9. Partner: no yes unknown - Living With partner? no yes unknown
10. Country of residence, if other than Canada: _____ unknown
11. Province of residence: _____ unknown
12. First 3 digits of postal code: _____ unknown

General Comments: _____

**SARS-COV-2 HISTORY, MATERNAL TESTING, SYMPTOMS, TREATMENTS, & HOSPITALIZATIONS
THROUGH FOLLOW-UP FORMS**

SARS-COV-2 EXPOSURE HISTORY**NOTE:** Record all testing information on Maternal and Infant SARS-COV 2 Testing DCFs:

Maternal testing on page 3, Infant testing on page 14 of the INTRAPARTUM DATA COLLECTION FORMS

1. Exposure information	Dates, if known (dd.mmm.yyyy)
I. <input type="checkbox"/> Travel, if yes, countr(ies): _____ II. <input type="checkbox"/> Known contact in community III. <input type="checkbox"/> Occupational risk, specify: IV. <input type="checkbox"/> Unknown V. <input type="checkbox"/> Other, describe: _____	
2. Comments:	

MATERNAL SARS-COV-2 TESTING

NOTE: Please include all maternal SARS-COV-2 testing results, record infant testing on page 14 of the INTRAPARTUM DATA COLLECTION FORMS

1. Specimen	Collection Date / Time (dd.mmm.yyyy/hh.mm)	Lab Report Date (dd.mmm.yyyy)	Test	Result
<input type="checkbox"/> Nasopharyngeal swab #1	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown If Pos, Sars-CoV-2 variant: <input type="checkbox"/> B.1.1.7 (UK) <input type="checkbox"/> B.1.351 (S Africa) <input type="checkbox"/> P.1 (Brazil) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Not tested/Unk
<input type="checkbox"/> Nasopharyngeal swab #2	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown If Pos, Sars-CoV-2 variant: <input type="checkbox"/> B.1.1.7 (UK) <input type="checkbox"/> B.1.351 (S Africa) <input type="checkbox"/> P.1 (Brazil) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Not tested/Unk
<input type="checkbox"/> Nasopharyngeal swab #3	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown If Pos, Sars-CoV-2 variant: <input type="checkbox"/> B.1.1.7 (UK) <input type="checkbox"/> B.1.351 (S Africa) <input type="checkbox"/> P.1 (Brazil) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Not tested/Unk
<input type="checkbox"/> Nasopharyngeal swab #4*	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown If Pos, Sars-CoV-2 variant: <input type="checkbox"/> B.1.1.7 (UK) <input type="checkbox"/> B.1.351 (S Africa) <input type="checkbox"/> P.1 (Brazil) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Not tested/Unk
<input type="checkbox"/> Throat swab	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown
<input type="checkbox"/> Blood	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown
<input type="checkbox"/> Breast Milk	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown

<input type="checkbox"/> Amniotic fluid	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown
<input type="checkbox"/> Serology – IgM	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown
<input type="checkbox"/> Serology – IgG	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown
<input type="checkbox"/> Other SARS-COV-2 testing if clinically indicated: _____	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown If Pos, Sars-CoV-2 variant: <input type="checkbox"/> B.1.1.7 (UK) <input type="checkbox"/> B.1.351 (S Africa) <input type="checkbox"/> P.1 (Brazil) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Not tested/Unk
<input type="checkbox"/> Other SARS-COV-2 testing if clinically indicated: _____	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown If Pos, Sars-CoV-2 variant: <input type="checkbox"/> B.1.1.7 (UK) <input type="checkbox"/> B.1.351 (S Africa) <input type="checkbox"/> P.1 (Brazil) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Not tested/Unk
<input type="checkbox"/> Other SARS-COV-2 testing if clinically indicated: _____	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown If Pos, Sars-CoV-2 variant: <input type="checkbox"/> B.1.1.7 (UK) <input type="checkbox"/> B.1.351 (S Africa) <input type="checkbox"/> P.1 (Brazil) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Not tested/Unk

*If more than 4 nasal swabs done, specify under "Other SARS-COV-2 testing if clinically indicated"

Other tests performed?

2. Influenza: no yes unknown, **If yes:** Date: _____ positive negative unknown
IF positive: positive for influenza A positive for influenza B

3. Respiratory-Syncytial Virus: no yes unknown, **If yes:** Date: _____ pos neg unknown

General Comments: _____

MATERNAL CLINICAL PRESENTATION

NOTE: Please record all symptoms imaging, complications, treatments and medications during follow-up. Record information available and update as necessary.

NOTE: Record all medications and supplements taken for COVID on COVID medications form (p.9-11) and other medications on General Medications & Supplements form. Add all SARS-Cov-2 testing to testing DCF on page 3 for maternal testing and for infant testing on page 14 of the INTRAPARTUM DATA COLLECTION FORMS

1. Date of COVID diagnosis, if known (dd.mmm.yyyy): _____

2. Estimated date of acquisition, if known (dd.mmm.yyyy): _____

3. Illness onset date, if known (dd.mmm.yyyy): _____

4. Asymptomatic at presentation? no (if no, proceed to symptoms table below)

yes (if yes, patient asymptomatic, skip symptoms table)

5. Symptoms during COVID illness episode:		
I. Fever <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk <input type="checkbox"/> < 38°C <input type="checkbox"/> 38-39°C <input type="checkbox"/> >39°C <input type="checkbox"/> Unk	II. Cough <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	III. Headache <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
IV. Shortness of breath <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	V. Runny nose <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	VI. Muscle pain/myalgia <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
VII. Anorexia (loss of appetite) <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	VIII. Diarrhea <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	IX. Vomiting <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
X. Malaise <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XI. Fatigue <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XII. Anosmia or ageusia (loss of smell or taste): <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
XIII. Sore throat <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XIV. Sputum production <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XV. Nausea <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
XVI. Non-specific respiratory symptoms <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XVII. Other Sx: _____ <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XVIII. Other Sx: _____ <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk

6. COMPLICATIONS (at any time, in pregnancy or postpartum)

- | | | | | |
|-------|--|---|--------------------------------------|-----------------|
| I. | Pneumonia | <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk | Date: _____ | Duration? _____ |
| II. | Sepsis | <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk | Date: _____ | Duration? _____ |
| III. | Respiratory Failure | <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk | Date: _____ | Duration? _____ |
| IV. | Acute Respiratory Distress Syndrome | <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk | Date: _____ | Duration? _____ |
| V. | Heart Failure | <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk | Date: _____ | Duration? _____ |
| VI. | Septic Shock | <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk | Date: _____ | Duration? _____ |
| VII. | Coagulopathy | <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk | Date: _____ | Duration? _____ |
| VIII. | Renal Failure | <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk | Date: _____ | Duration? _____ |
| IX. | Liver dysfunction | <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk | Date: _____ | Duration? _____ |
| X. | Disseminated intravascular coagulopathy | <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk | Date: _____ | Duration? _____ |
| XI. | Hospital Admission
*For those hospitalized, complete hospitalization form | <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk | Date: _____ | Duration? _____ |
| XII. | Maternal Death | <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk | *If yes complete maternal death form | |
| XIII. | Other, Specify: | <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk | Date: _____ | Duration? _____ |

7. CHEST IMAGING:

- | | | | | |
|-----|-------------------------|---|-------------|----------------------------------|
| I. | X-ray test performed? | <input type="checkbox"/> no <input type="checkbox"/> yes | Date: _____ | <input type="checkbox"/> unknown |
| | | <input type="checkbox"/> abnormal <input type="checkbox"/> normal <input type="checkbox"/> pending <input type="checkbox"/> unk | | |
| | | If abnormal, result: _____ | | |
| II. | Second X-ray performed? | <input type="checkbox"/> no <input type="checkbox"/> yes | Date: _____ | <input type="checkbox"/> unknown |
| | | <input type="checkbox"/> abnormal <input type="checkbox"/> normal <input type="checkbox"/> pending <input type="checkbox"/> unk | | |
| | | If abnormal, result: _____ | | |

- III. CT scan test performed? no yes Date: _____ unknown
 abnormal normal pending unk
 If abnormal, result: _____
- IV. Second CT performed? no yes Date: _____ unknown
 abnormal normal pending unk
 If abnormal, result: _____
- V. MRI test performed? no yes Date: _____ unknown
 abnormal normal pending unk
 If abnormal, result: _____
- VI. Second MRI performed? no yes Date: _____ unknown
 abnormal normal pending unk
 If abnormal, result: _____
- VII. Other chest imaging, Specify: no yes Date: _____ unknown
 abnormal normal pending unk
 _____ If abnormal, result: _____

8. OTHER IMAGING (non-chest):

- a. no yes unk Imaging type: _____ Date: _____
 abnormal normal pending unk
 If abnormal, result: _____
- b. no yes unk Imaging type: _____ Date: _____
 abnormal normal pending unk
 If abnormal, result: _____
- c. no yes unk Imaging type: _____ Date: _____
 abnormal normal pending unk
 If abnormal, result: _____

9. TREATMENT

Were any of the following treatments performed? yes no unk

- | | | | | |
|-------|---|------------|------------------------------------|---|
| I. | <input type="checkbox"/> Intravenous immunoglobulin | Date _____ | Duration _____ | Dose _____ |
| II. | <input type="checkbox"/> Oxygen (outside of at delivery)? | Date _____ | Duration (days, CUMULATIVE): _____ | Maximal therapy delivered,
L per minute: _____ |
| III. | <input type="checkbox"/> High-flow nasal cannula oxygen therapy | Date _____ | Duration _____ | |
| IV. | <input type="checkbox"/> Invasive mechanical ventilation | Date _____ | Duration _____ | |
| V. | <input type="checkbox"/> Non-invasive mechanical ventilation | Date _____ | Duration _____ | |
| VI. | <input type="checkbox"/> ECMO | Date _____ | Duration _____ | |
| VII. | <input type="checkbox"/> Renal replacement therapy | Date _____ | Duration _____ | |
| VIII. | <input type="checkbox"/> Vasopressors | Date _____ | Duration _____ | |
| IX. | <input type="checkbox"/> Other, specify _____ | Date _____ | Duration _____ | |
| X. | <input type="checkbox"/> Other, specify _____ | Date _____ | Duration _____ | |
| XI. | <input type="checkbox"/> Other, specify _____ | Date _____ | Duration _____ | |

General Comments: _____

COVID-19 MEDICATIONS AND NATURAL HEALTH PRODUCTS

NOTE: Please record medications, OTC and prescription, and natural health products, taken in pregnancy and birth for COVID-19 here. Record postpartum COVID medications on postpartum forms. Record medications for other indications on General Medications form.

OVER THE COUNTER MEDICATIONS: <input type="checkbox"/> No over the counter medications <input type="checkbox"/> Unknown			
1. <input type="checkbox"/> OTC meds (check all taken)			
<input type="checkbox"/> Acetaminophen (Tylenol)			
<input type="checkbox"/> NSAIDS			
<input type="checkbox"/> Acetylsalicylic acid (Aspirin)			
<input type="checkbox"/> Ibuprofen (Advil, Motrin, others)			
<input type="checkbox"/> Naproxen (Aleve, Naprosyn, others)			
<input type="checkbox"/> Other _____			
<input type="checkbox"/> Other _____			
<input type="checkbox"/> Other: _____			
PRESCRIPTION MEDICATIONS: <input type="checkbox"/> No prescription medications <input type="checkbox"/> Unknown			
2. <input type="checkbox"/> Corticosteroids (check all taken)	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
<input type="checkbox"/> Dexamethasone	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
3. <input type="checkbox"/> Steroids for fetal lung maturation, specify:	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
4. <input type="checkbox"/> Chloroquine. If yes, describe circumstance:	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
5. <input type="checkbox"/> Hydroxychloroquine. If yes, describe circumstance:	<input type="checkbox"/> Clinical trial?	Dose:	Duration:

6. <input type="checkbox"/> Colchicine	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
7. <input type="checkbox"/> Antiviral (check all taken) <input type="checkbox"/> Kaletra (Lopinavir/Ritonavir) <input type="checkbox"/> Remdesivir <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Clinical trial? <input type="checkbox"/> Clinical trial? <input type="checkbox"/> Clinical trial? <input type="checkbox"/> Clinical trial?	Dose: Dose: Dose: Dose:	Duration: Duration: Duration: Duration:
8. <input type="checkbox"/> Antibiotics (check all taken) <input type="checkbox"/> Specify _____ <input type="checkbox"/> Specify _____	<input type="checkbox"/> Clinical trial? <input type="checkbox"/> Clinical trial?	Dose: Dose:	Duration: Duration:
9. <input type="checkbox"/> Other _____	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
10. <input type="checkbox"/> Other _____	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
11. <input type="checkbox"/> Other _____	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
12. <input type="checkbox"/> Other _____	<input type="checkbox"/> Clinical trial?	Dose:	Duration:

NATURAL HEALTH PRODUCTS FOR COVID: No natural health products Unknown

13. Natural health products

Specify _____

Specify _____

Specify _____

Specify _____

General Comments: _____

HOSPITALIZATION FORM

1. Symptoms at admission (outside of admission for delivery):		
I. Fever <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk <input type="checkbox"/> < 38°C <input type="checkbox"/> 38-39°C <input type="checkbox"/> >39°C <input type="checkbox"/> Unk	II. Cough <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	III. Headache <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
IV. Shortness of breath <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	V. Runny nose <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	VI. Muscle pain/myalgia <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
VII. Anorexia (loss of appetite) <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	VIII. Diarrhea <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	IX. Vomiting <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
X. Malaise <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XI. Fatigue <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XII. Anosmia or ageusia (loss of smell or taste): <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
XIII. Sore throat <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XIV. Sputum production <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XV. Nausea <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
XVI. Non-specific respiratory symptoms <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XVII. Other Sx: _____ <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XVIII. Other Sx: _____ <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk

2. Admitted to ICU? yes no unknown

ICU Admission Date: _____ Duration of stay: _____

3. Highest patient temperature? <38°C 38-39°C > 39°C unknown

4. Maternal heart rate at admission (bpm)

<100 bpm (NORMAL) 100-110 bpm 111-120 bpm >120 bpm unk

5. Maternal systolic blood pressure at admission (mmHg): _____

6. Maternal diastolic blood pressure at admission (mmHg): _____

7. Respiratory rate of admission (/min):

<22/min 22-34/min > 34/min unknown

8. Peripheral oxygen saturation at admission (SpO₂%): _____

9. Altered mental status: yes no unknown

10. ECG at admission: yes no unknown

If yes, ECG result: normal abnormal unknown

11. Abnormal lab result if tested, for the following while inpatient:

I. Platelet count Within normal range? Yes No If no, value _____ Date: _____ unk no test

II. White blood count
(WBC) Within normal range? Yes No If no, value _____ Date: _____ unk no test

III. Haemoglobin Within normal range? Yes No If no, lowest value _____ Date: _____
 unk no test

IV. CRP Within normal range? Yes No If no, highest value _____ Date: _____
 unk no test

V. Lactate dehydrogenase
(U/L >245) Within normal range? Yes No If no, High? Low? Worst value _____
Date: _____ unk no test

VI. ALT (U/L >40) Within normal range? Yes No If no, High? Low? Worst value: _____
Date: _____ unk no test

VII. Creatinine Within normal range? Yes No If no, highest value _____ Date: _____
 unk no test

VIII. Uric acid Within normal range? Yes No If no, highest value _____ Date: _____
 unk no test

General Comments: _____

ANTEPARTUM DATA COLLECTION FORMS

PREGNANCY HISTORY

Please provide information on all prior pregnancies.

NOTE: : T/a = Therapeutic abortion ; S/a= Spontaneous abortion

1. I. # Gravida ____ <input type="checkbox"/> Unknown II. # Term ____ <input type="checkbox"/> Unknown III. # Preterm ____ <input type="checkbox"/> Unknown IV. # Abortion ____ (Induced ____ <input type="checkbox"/> Unknown Spontaneous ____ <input type="checkbox"/> Unknown) V. # Living ____ <input type="checkbox"/> Unknown					Children		
	Year of birth/ event	Gest. Age (wks & days)	Type of birth	Perinatal complications	Sex	Birth weight	Present health (alive and well/ demised/ significant health issue)
2.		<input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Vag <input type="checkbox"/> C/s <input type="checkbox"/> T/a <input type="checkbox"/> S/a <input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Preeclampsia <input type="checkbox"/> Intrauterine Growth Restriction <input type="checkbox"/> Fetal Malformation <input type="checkbox"/> Preterm birth <input type="checkbox"/> Postpartum hemorrhage <input type="checkbox"/> Other, specify: <input type="checkbox"/> N/a		<input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Alive/ well <input type="checkbox"/> Demised <input type="checkbox"/> Significant health issue: <input type="checkbox"/> Unk <input type="checkbox"/> N/a
3.		<input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Vag <input type="checkbox"/> C/s <input type="checkbox"/> T/a <input type="checkbox"/> S/a <input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Preeclampsia <input type="checkbox"/> Intrauterine Growth Restriction <input type="checkbox"/> Fetal Malformation <input type="checkbox"/> Preterm birth <input type="checkbox"/> Postpartum hemorrhage <input type="checkbox"/> Other, specify: <input type="checkbox"/> N/a		<input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Alive/ well <input type="checkbox"/> Demised <input type="checkbox"/> Significant health issue: <input type="checkbox"/> Unk <input type="checkbox"/> N/a
4.		<input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Vag <input type="checkbox"/> C/s <input type="checkbox"/> T/a <input type="checkbox"/> S/a <input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Preeclampsia <input type="checkbox"/> Intrauterine Growth Restriction <input type="checkbox"/> Fetal Malformation <input type="checkbox"/> Preterm birth <input type="checkbox"/> Postpartum hemorrhage <input type="checkbox"/> Other, specify: <input type="checkbox"/> N/a		<input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Alive/ well <input type="checkbox"/> Demised <input type="checkbox"/> Significant health issue: <input type="checkbox"/> Unk <input type="checkbox"/> N/a
5.		<input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Vag <input type="checkbox"/> C/s <input type="checkbox"/> T/a <input type="checkbox"/> S/a <input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Preeclampsia <input type="checkbox"/> Intrauterine Growth Restriction <input type="checkbox"/> Fetal Malformation <input type="checkbox"/> Preterm birth <input type="checkbox"/> Postpartum hemorrhage <input type="checkbox"/> Other, specify: <input type="checkbox"/> N/a		<input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Alive/ well <input type="checkbox"/> Demised <input type="checkbox"/> Significant health issue: <input type="checkbox"/> Unk <input type="checkbox"/> N/a
6.		<input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Vag <input type="checkbox"/> C/s <input type="checkbox"/> T/a <input type="checkbox"/> S/a <input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Preeclampsia <input type="checkbox"/> Intrauterine Growth Restriction <input type="checkbox"/> Fetal Malformation <input type="checkbox"/> Preterm birth <input type="checkbox"/> Postpartum hemorrhage <input type="checkbox"/> Other, specify: <input type="checkbox"/> N/a		<input type="checkbox"/> Unk <input type="checkbox"/> N/a	<input type="checkbox"/> Alive/ well <input type="checkbox"/> Demised <input type="checkbox"/> Significant health issue: <input type="checkbox"/> Unk <input type="checkbox"/> N/a

General Comments: _____

PREGNANCY INFORMATION

1. Calculated LMP (dd/mmm/yyyy): <input type="checkbox"/> Unknown _____							
2. Confirmed estimated date of delivery (dd/mmm/yyyy): _____ I. Based on (best available method): <input type="checkbox"/> Last menstrual period <input type="checkbox"/> First trimester ultrasound with an embryo \geq 10mm <input type="checkbox"/> Ultrasound (if second trimester +) <input type="checkbox"/> Unknown							
3. IVF pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes -> Specify _____ <input type="checkbox"/> Unknown							
4. Alcohol use in pregnancy: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown I. Binge drinking in pregnancy: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown							
5. Substance use in pregnancy (outside of medications prescribed to patient): <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown I. If yes, <input type="checkbox"/> Heroin <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana <input type="checkbox"/> Solvents <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown							
6. Smoking before pregnancy: <input type="checkbox"/> Never <input type="checkbox"/> Quit (DD/MMM/YYYY) _____ <input type="checkbox"/> Unknown I. If yes, average # cigarettes ____ /day OR ____ / week <input type="checkbox"/> Unknown							
7. Smoking during pregnancy: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown I. If yes, average # cigarettes ____ /day OR ____ / week <input type="checkbox"/> Unknown							
8. Exposure 2nd hand smoke during pregnancy: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown							
9. Height (cm): <input type="checkbox"/> Unknown	10. Weight pre / early pregnancy (kg; weight right before pregnancy or earliest recorded in pregnancy): <input type="checkbox"/> Unknown						
11. # Fetuses: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> \geq 4, specify # : _____ <input type="checkbox"/> Unknown I. If multiples: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Twin: Dichorionic Diamniotic</td> <td style="width: 50%;"><input type="checkbox"/> Twin: Monochorionic Diamniotic</td> </tr> <tr> <td><input type="checkbox"/> Twin: Monochorionic Monoamniotic</td> <td><input type="checkbox"/> Triplets: specify _____</td> </tr> <tr> <td><input type="checkbox"/> Other, specify _____</td> <td><input type="checkbox"/> Unknown</td> </tr> </table>		<input type="checkbox"/> Twin: Dichorionic Diamniotic	<input type="checkbox"/> Twin: Monochorionic Diamniotic	<input type="checkbox"/> Twin: Monochorionic Monoamniotic	<input type="checkbox"/> Triplets: specify _____	<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Unknown
<input type="checkbox"/> Twin: Dichorionic Diamniotic	<input type="checkbox"/> Twin: Monochorionic Diamniotic						
<input type="checkbox"/> Twin: Monochorionic Monoamniotic	<input type="checkbox"/> Triplets: specify _____						
<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Unknown						

General Comments: _____

COMORBIDITIES IN PREGNANCY

Please report maternal health comorbidities in pregnancy

1. no comorbidities, skip to pregnancy screening

NOTE: Record all medications on COVID medications / General medications forms

Check all that apply

BODY SYSTEM	DIAGNOSIS	MEDICATIONS
i. CNS - Central Nervous System <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Chronic headaches	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Migraines	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Epilepsy	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Other _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
ii. EENT+M - Ears, Eyes, Nose Throat & Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <small>*Allergies go in xiii. Allergies/ immune</small>	<input type="checkbox"/> Specify: _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Specify: _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
iii. CVS – Cardiovascular <div style="border: 1px solid black; padding: 2px; width: fit-content;"> If gest hypertension, document under complications related to pregnancy page 10 </div> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Hypertension	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Arrhythmia: _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Valve conditions	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Other _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form

BODY SYSTEM	DIAGNOSIS	MEDICATIONS
iv. RESP - Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Asthma	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Chronic obstructive lung disease	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Other _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
v. GI - Gastrointestinal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Irritable bowel disease (IBD)	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Celiac	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Other	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
vi. GU – Genitourinary <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Recurrent urinary tract infection (UTI)	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Other _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Other _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
vii. REPRO – Reproductive <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Short cervix history	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Short cervix current preg	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Other _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form

BODY SYSTEM	DIAGNOSIS	MEDICATIONS
viii. ENDO – Endocrine <div style="border: 1px solid black; padding: 2px; margin: 5px 0;"> If gest diabetes, document under complications related to pregnancy, page 10 </div> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Thyroid function imbalances <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Other _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Diabetes type 1	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Diabetes type 2	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Other _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
ix. MS - Musculoskeletal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Rheumatoid arthritis	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Ankylosing spondylitis	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Lupus _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Other _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form

BODY SYSTEM	DIAGNOSIS	MEDICATIONS
x. HEM - Hematologic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Thrombocytopenia	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Deep vein thrombosis (DVT)	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Immune thrombocytopenic purpura (ITP)	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Anemia	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Other _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
xi. MH - Mental Health <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Depression	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Anxiety	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Schizophrenia	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Bipolar	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Other _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form

BODY SYSTEM	DIAGNOSIS	MEDICATIONS
xii. AAI - Allergies / Autoimmune Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Allergies, Drug, specify:	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Allergies, environmental/ food specify:	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
	<input type="checkbox"/> Other _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
xiii. Other 1 _____ ↑ body system ↑ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Other _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form
xiv. Other 2 _____ ↑ body system ↑ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Other _____	Taking medication? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk * If yes, indicate in General Meds Form

General Comments: _____

PREGNANCY SCREENING

1. Aneuploidy screening

Screening test if available	unknown	not done	date, if done (dd/mmm/yyyy)	Result	Comments
i. NIPT	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> neg/norm <input type="checkbox"/> pos <input type="checkbox"/> unk	
ii. Serum Screening	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> neg/norm <input type="checkbox"/> pos <input type="checkbox"/> unk	
iii. Amniocentesis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> neg/norm <input type="checkbox"/> pos <input type="checkbox"/> unk	
iv. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> neg/norm <input type="checkbox"/> pos <input type="checkbox"/> unk	

2. Infectious serotesting

- | | | | | |
|------------------------------|--|--|------------------------------|-------------------------------------|
| i. HIV | <input type="checkbox"/> neg/ unreactive | <input type="checkbox"/> pos/ reactive | <input type="checkbox"/> unk | <input type="checkbox"/> not tested |
| ii. HBV sAg | <input type="checkbox"/> neg/ unreactive | <input type="checkbox"/> pos/ reactive | <input type="checkbox"/> unk | <input type="checkbox"/> not tested |
| iii. HCV | <input type="checkbox"/> neg/ unreactive | <input type="checkbox"/> pos/ reactive | <input type="checkbox"/> unk | <input type="checkbox"/> not tested |
| iv. GBS | <input type="checkbox"/> neg/ unreactive | <input type="checkbox"/> pos/ reactive | <input type="checkbox"/> unk | <input type="checkbox"/> not tested |
| v. Syphilis | <input type="checkbox"/> neg/ unreactive | <input type="checkbox"/> pos/ reactive | <input type="checkbox"/> unk | <input type="checkbox"/> not tested |
| vi. Gonorrhoea | <input type="checkbox"/> neg/ unreactive | <input type="checkbox"/> pos/ reactive | <input type="checkbox"/> unk | <input type="checkbox"/> not tested |
| vii. Chlamydia | <input type="checkbox"/> neg/ unreactive | <input type="checkbox"/> pos/ reactive | <input type="checkbox"/> unk | <input type="checkbox"/> not tested |
| viii. Rubella | <input type="checkbox"/> neg/ unreactive | <input type="checkbox"/> pos/ reactive | <input type="checkbox"/> unk | <input type="checkbox"/> not tested |
| viii. Varicella Zoster Virus | <input type="checkbox"/> neg/ unreactive | <input type="checkbox"/> pos/ reactive | <input type="checkbox"/> unk | <input type="checkbox"/> not tested |
| ix. Other: _____ | <input type="checkbox"/> neg/ unreactive | <input type="checkbox"/> pos/ reactive | <input type="checkbox"/> unk | <input type="checkbox"/> not tested |
| x. Other: _____ | <input type="checkbox"/> neg/ unreactive | <input type="checkbox"/> pos/ reactive | <input type="checkbox"/> unk | <input type="checkbox"/> not tested |
| xi. Other: _____ | <input type="checkbox"/> neg/ unreactive | <input type="checkbox"/> pos/ reactive | <input type="checkbox"/> unk | <input type="checkbox"/> not tested |
| xii. Other: _____ | <input type="checkbox"/> neg/ unreactive | <input type="checkbox"/> pos/ reactive | <input type="checkbox"/> unk | <input type="checkbox"/> not tested |
| xiii: Comments: | | | | |

COMPLICATIONS RELATED TO PREGNANCY

During this pregnancy, did any of the following occur?

NOTE 1: In the event of a pregnancy loss, document on Pregnancy Loss form

NOTE 2: This form should include all pregnancy – complete with available information & update through to end preg

NOTE 3: Record all medications for COVID indication in COVID medications table on page 9-11 in SARS-COV-2

HISTORY, MATERNAL TESTING, SYMPTOMS, TREATMENTS, & HOSPITALIZATIONS THROUGH FOLLOW-UP forms

NOTE 4: Records all other medications in General Medications form

Data abstraction complete through delivery? no yes Unk

Event	Occurred?	Date(s) (if unk: month, GA or trimester)	Comments
1. Bleeding	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk		I. Etiology? <input type="checkbox"/> Placental abruption <input type="checkbox"/> Placenta previa <input type="checkbox"/> Cervix <input type="checkbox"/> Other, specify: <input type="checkbox"/> Unk
2. Progesterone given to prevent premature birth	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk		
3. Cerclage	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk	Surgery date:	
4. Preterm premature rupture of membranes	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk		
5. Preterm labour	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk		
6. Cholestasis of pregnancy	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk		
7. Hypertensive disorder of pregnancy	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk		
8. Gestational diabetes	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk		<input type="checkbox"/> Diet controlled <input type="checkbox"/> Insulin controlled <input type="checkbox"/> Metformin <input type="checkbox"/> Unknown
9. Pregnancy Loss	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk		DOCUMENT ON PREGNANCY LOSS FORM
10. Other _____	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> Unk		

General Comments: _____

ULTRASOUND RESULTS – Complete separate form for each ultrasound (Ultrasound #____of____)

1. Date (dd.mmm.yyyy): _____		Dating ultrasound: <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	
2. Measurements	I. Head circumference:	IV. Crown-rump length:	
	II. Femur length:	V. Biparietal diameter:	
	III. Abdominal circumference:	VI. Estimated fetal weight:	
3. Oligohydramnios (Low fluid)*	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk *single deepest pocket <2 cm or amniotic fluid index <5 cm (or lab diagnosis)		
4. Polyhydramnios (High fluid)**	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk **single deepest pocket >8 cm or amniotic fluid index ≥25 cm (or lab diagnosis)		
5. Intrauterine growth restriction***	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk I. If yes, percentage: _____ *** AC/EFW < 3rd percentile		
6. Placental abnormality	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk I. If yes: <input type="checkbox"/> Placenta previa <input type="checkbox"/> Other, specify _____		
7. Anatomic abnormalities	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk I. If yes: <input type="checkbox"/> Neural tube defect, specify _____ <input type="checkbox"/> Heart defect, specify _____ <input type="checkbox"/> Polydactyly, specify _____ <input type="checkbox"/> Cleft palate <input type="checkbox"/> Cerebral anomaly, specify _____ <input type="checkbox"/> Other, specify _____		
8. Other Abnormalities	<input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk I. If yes, describe:		

General Comments: _____

IMMUNIZATIONS

RELEVANT IMMUNIZATIONS
<p>1. Received an Influenza vaccine in this season?</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown</p> <p>I. If yes, date(s) of immunization – if available: _____(dd.mmm.yyyy)</p>
<p>2. Received a TDAP vaccine this pregnancy?</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown</p> <p>II. If yes, date(s) of immunization – if available: _____(dd.mmm.yyyy)</p>
<p>3. History of COVID vaccine?</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown</p> <p>If yes, in pregnancy? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown</p> <p>III. Dose 1, date of immunization – if available: _____(dd.mmm.yyyy) Dose 1, type: <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> AstraZeneca <input type="checkbox"/> Johnson & Johnson / Janssen <input type="checkbox"/> Novavax <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown</p> <p>IV. Dose 2, date of immunization – if available: _____(dd.mmm.yyyy) Dose 2, type: <input type="checkbox"/> Pfizer-BioNTech <input type="checkbox"/> Moderna <input type="checkbox"/> AstraZeneca <input type="checkbox"/> Johnson & Johnson / Janssen <input type="checkbox"/> Novavax <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown</p>
<p>4. Has the case received any other vaccines during pregnancy?</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown</p> <p>V. If yes, date(s) of immunization – if available: _____(dd.mmm.yyyy)</p>

General Comments: _____

PREGNANCY LOSS**NOTE: Please complete in the event of pregnancy loss. If multiple fetuses, specify fetus A/B/C.**

1. Date of diagnosis of intrauterine fetal demise/ miscarriage/ or termination: _____				
2. Gestational age a time of loss: _____ weeks				
3. Elective termination? <input type="checkbox"/> no <input type="checkbox"/> yes				
4. Spontaneous termination? <input type="checkbox"/> no <input type="checkbox"/> yes				
5. Still birth / intrauterine demise (greater than 20 weeks)? <input type="checkbox"/> no <input type="checkbox"/> yes				
I. If yes: <input type="checkbox"/> antepartum <input type="checkbox"/> intrapartum <input type="checkbox"/> unknown				
6. Autopsy completed? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unknown				
7. Examination findings:				
8. Pathologic including cytogenetic diagnoses:				
9. Cause of death:				
SARS-COV-2 Products of loss testing? <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk <input type="checkbox"/> decidua <input type="checkbox"/> placenta <input type="checkbox"/> cord blood <input type="checkbox"/> fetal blood <input type="checkbox"/> fetal swabs <input type="checkbox"/> Other, specify _____	Collection Date / Time (dd.mmm.yyyy / hh.mm)	Lab Report Date (dd.mmm.yyyy)	Test	Result <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown

INTRAPARTUM DATA COLLECTION FORMS

DELIVERY INFORMATION - MATERNAL

1. Symptoms intrapartum <input type="checkbox"/> no- asymptomatic <input type="checkbox"/> yes <input type="checkbox"/> unk		
I. Fever <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk <input type="checkbox"/> < 38°C <input type="checkbox"/> 38-39°C <input type="checkbox"/> >39°C <input type="checkbox"/> Unk	II. Cough <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	III. Headache <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
IV. Shortness of breath <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	V. Runny nose <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	VI. Muscle pain/myalgia <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
VII. Anorexia (loss of appetite) <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	VIII. Diarrhea <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	IX. Vomiting <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
X. Malaise <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XI. Fatigue <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XII. Anosmia or ageusia (loss of smell or taste): <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
XIII. Sore throat <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XIV. Sputum production <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XV. Nausea <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
XVI. Non-specific respiratory symptoms <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XVII. Other Sx: _____ <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XVIII. Other Sx: _____ <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk

2. **Number of fetuses:** 1 2 3+

3. **Outcome of pregnancy:** Pregnancy loss (<20 weeks or <500g) ****Complete Pregnancy Loss Form**
 Stillbirth (>20 weeks or >500g) ****Complete Pregnancy Loss Form**
 Live birth
 Unknown *Note: If multiples with differing outcomes, contact coordinating centre

4. **Labour:**

- No labour
 Spontaneous
 Induced, indication: Antepartum hemorrhage Autoimmune disease
 Augmented Chorioamnionitis Intrauterine growth restriction
 Unknown Suspected fetal compromise Oligohydramnios
 Pre-labour rupture of membranes COVID-19
 Postdates Other, specify: _____
 Unknown

5. **Type of anesthesia:** None Spinal Epidural Entonox General-intubated
 Unk Other, specify: _____

6. **Mode:** vaginal C/S: elective urgent emergent C/S, indication: _____

7. **Length of rupture of membrane:** (HH) _____ (MM) _____

8. **Delivery complications**

I. Transfusion no yes unknown

II. Chorioamnionitis no yes unknown

III. Highest temperature recorded: _____ °C

IV. Fever in labour (37.5°C+ or documented fever) no yes unknown

If available, highest temperature recorded: _____ °C

a. Reason for fever in labour:

- Asymptomatic fever (e.g., misoprostol)
 Symptomatic fever, OB related (chorioamnionitis, endometritis)
 Sepsis, OB related (chorioamnionitis, endometritis)
 COVID-related fever
 Other reason for fever, specify: _____
 Unknown

II. Other delivery complications no yes unknown

If yes, Describe: _____

9. Were cultures done for any reason? no yes, describe below unknown

Urine, blood, resp	Date / time collected	Result
i. _____	Date: Time:	<input type="checkbox"/> neg <input type="checkbox"/> pos <input type="checkbox"/> unk Pathogen(s): _____
ii. _____	Date: Time:	<input type="checkbox"/> neg <input type="checkbox"/> pos <input type="checkbox"/> unk Pathogen(s): _____

10. Maternal transfer/ discharge:

- Transfer to postpartum ward then discharged home
 Transfer to other organization
 Transfer to different ward; Reason: _____
 Transfer to ICU/CCU
*Complete hospitalization form
 Maternal death (complete maternal death form)
 Unknown

11. Maternal discharge date (if applicable): _____

General Comments: _____

Postpartum Medications for COVID Intrapartum Through Discharge - Maternal

NOTE: Record other medications on General Medications form

OVER THE COUNTER MEDICATIONS: <input type="checkbox"/> No over the counter medications <input type="checkbox"/> Unknown			
1. <input type="checkbox"/> OTC meds (check all taken)			
<input type="checkbox"/> Acetaminophen (Tylenol)			
<input type="checkbox"/> NSAIDS			
<input type="checkbox"/> Acetylsalicylic acid (Aspirin)			
<input type="checkbox"/> Ibuprofen (Advil, Motrin, others)			
<input type="checkbox"/> Naproxen (Aleve, Naprosyn, others)			
<input type="checkbox"/> Other _____			
<input type="checkbox"/> Other _____			
<input type="checkbox"/> Other: _____			
PRESCRIPTION MEDICATIONS: <input type="checkbox"/> No prescription medications <input type="checkbox"/> Unknown			
2. <input type="checkbox"/> Corticosteroids (check all taken)			
<input type="checkbox"/> Dexamethasone	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
3. <input type="checkbox"/> Chloroquine. If yes, describe circumstance:	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
4. <input type="checkbox"/> Hydroxychloroquine. If yes, describe circumstance:	<input type="checkbox"/> Clinical trial?	Dose:	Duration:
5. <input type="checkbox"/> Colchicine	<input type="checkbox"/> Clinical trial?	Dose:	Duration:

<p>6. <input type="checkbox"/> Antiviral (check all taken)</p> <p><input type="checkbox"/> Kaletra (Lopinavir/Ritonavir)</p> <p><input type="checkbox"/> Remdesivir</p> <p><input type="checkbox"/> Other, specify _____</p> <p><input type="checkbox"/> Other, specify _____</p>	<p><input type="checkbox"/> Clinical trial?</p> <p><input type="checkbox"/> Clinical trial?</p> <p><input type="checkbox"/> Clinical trial?</p> <p><input type="checkbox"/> Clinical trial?</p>	<p>Dose:</p> <p>Dose:</p> <p>Dose:</p> <p>Dose:</p>	<p>Duration:</p> <p>Duration:</p> <p>Duration:</p> <p>Duration:</p>
<p>7. <input type="checkbox"/> Antibiotics (check all taken)</p> <p><input type="checkbox"/> Specify _____</p> <p><input type="checkbox"/> Specify _____</p>	<p><input type="checkbox"/> Clinical trial?</p> <p><input type="checkbox"/> Clinical trial?</p>	<p>Dose:</p> <p>Dose:</p>	<p>Duration:</p> <p>Duration:</p>
<p>8. <input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> Clinical trial?</p>	<p>Dose:</p>	<p>Duration:</p>
<p>9. <input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> Clinical trial?</p>	<p>Dose:</p>	<p>Duration:</p>
<p>10. <input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> Clinical trial?</p>	<p>Dose:</p>	<p>Duration:</p>
<p>NATURAL HEALTH PRODUCTS FOR COVID: <input type="checkbox"/> No natural health products <input type="checkbox"/> Unknown</p>			
<p>11. <input type="checkbox"/> Natural health products</p>	<p><input type="checkbox"/> Specify _____</p> <p><input type="checkbox"/> Specify _____</p> <p><input type="checkbox"/> Specify _____</p> <p><input type="checkbox"/> Specify _____</p>		

INFANT: DELIVERY THROUGH DISCHARGE

1. Singleton Twin Other, specify _____ *If multiples, please add additional pages*
2. If non-singleton delivery, information below is for: N/a Baby A Baby B Baby C
3. Date of birth (dd.mmm.yyyy) _____ Time of birth (HH:MM): _____
4. Place of birth: Hospital (Hospital Name*: _____) Home Other: _____ Unknown
*This information is classified as identifiable data
5. Iatrogenic preterm birth? no yes Unk 6. **Spontaneous preterm birth?** no yes Unk
7. Umbilical Cord pH (arterial): _____ Base excess: _____
8. Discharge Date of Infant (dd.mmm.yyyy): _____
(If not admitted to NICU for symptoms or different from maternal discharge date)

PLACENTA TESTING

9. Placental Pathology, including cytogenetics done? no yes unknown
If yes: normal abnormal
Describe result: _____
10. **Was placenta testing for SARS-COV-2 done?** no yes; if yes, describe below unknown

Specimen	Collection Date / Time (dd.mmm.yyyy / hh:mm)	Lab Report Date (dd.mmm.yyyy)	Test	Result
I. SARS-COV-2 Placenta testing	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown

General Comments: _____

DELIVERY ROOM MANAGEMENT (within first 30 minutes of life)**1. APGARs**1 min _____ 5 min _____ 10 min _____ 10min not done**Any oxygen & resuscitation needs?** yes no unk If yes:I. Free flow Unknown no yes, describe: _____II. IPPV per mask Unknown no yes, describe: _____III. Intubation Unknown no yes, describe: _____IV. CPAP Unknown no yes, describe: _____V. CPR Unknown no yes, describe: _____VI. Other Unknown no yes, describe: _____2. **Birth weight:** _____ lbs+oz / gm (circle) Unknown3. **Birth length:** _____ in/cm (circle) Unknown4. **Birth head Circ:** _____ in/cm (circle) Unknown5. **Delayed cord clamping:** no yes unknown

I. If yes, duration (seconds): _____

6. Initial physical examination

I. Date & time (leave blank if done at birth) _____

II. Respiratory exam normal abnormal not checkedIf abnormal: tachypnea dyspnea cyanosisIII. Cardiovascular system normal abnormal not checkedIf abnormal: poorly perfused heart murmur cyanosisIV. Abdominal system normal abnormal not checkedIf abnormal: hepatomegaly splenomegaly

V. Neurological system normal abnormal not checked

If abnormal: tone tendon reflexes power

VI. Genitalia male female ambiguous

VII. Dysmorphism no yes Unknown

If yes, please describe _____

VIII. Any other significant findings? no yes Unknown

If yes, Please describe: _____

7. **Screening for other infectious diseases?** no yes unknown

I. Specify _____ Date: _____ positive/abnormal negative/normal unknown

II. Specify _____ Date: _____ positive/abnormal negative/normal unknown

III. Specify _____ Date: _____ positive/abnormal negative/normal unknown

8. **Blood count:** no yes, date/time (if available): _____ unknown

I. positive/abnormal, specify _____ negative/normal unknown

9. **Other investigations?** no yes unknown

I. Specify _____ Date: _____ positive/abnormal negative/normal unknown

II. Specify _____ Date: _____ positive/abnormal negative/normal unknown

III. Specify _____ Date: _____ positive/abnormal negative/normal unknown

10. **Any infant health events / issues between birth and discharge:** yes no unknown

I. Jaundice no yes, describe: _____ unknown

la. Phototherapy: no yes unknown

II. Seizures no yes, describe: _____ unknown

III. Hypoglycemia (glucometer <2.6mmol/L) no yes, describe below unknown

IV. Infant death no yes *If yes, please complete infant death form unknown

V. Admission to NICU no yes (Complete NICU form, including all diagnoses in NICU) unknown

VI. Other no yes, describe _____ unknown

11. Infant Management:

NOTE: If mother and baby are both doing well/asymptomatic (e.g. if mother has recovered from COVID), select option A for mother, and leave three sub-options related to baby blank/unselected, as not applicable.

- A) Mother asymptomatic or mild symptoms: able to do self care out of hospital/ not hospitalized for COVID:
- Baby in joint isolation with mother in postpartum: with skin-to-skin contact and/or breastfeeding
 - Asymptomatic baby isolated away from mum: # of days isolated _____
-> Location of baby isolation: Postpartum ward Special Care Nursery or NICU Other: _____
 - Symptomatic baby transferred to SCN or NICU care
- B) Mother symptomatic requires ongoing hospitalization for management of COVID, but not critical care:
- Baby in joint isolation with mother in postpartum: with skin-to-skin contact and/or breastfeeding
 - Asymptomatic baby isolated away from mum: # of days isolated _____
-> Location of baby isolation: Postpartum ward Special Care Nursery or NICU Other: _____
 - Symptomatic baby transferred to SCN or NICU care
- C) Mother in critical care for COVID:
- Baby allowed close contact with mum - skin to skin contact or within 2 m
 - Asymptomatic baby isolated away from mum # of days isolated _____
-> Location of baby isolation: Postpartum ward Special Care Nursery or NICU Other: _____
 - Symptomatic baby transferred to SCN or NICU care
- D) Unknown
- E) Other, specify: _____

12. Was breastfeeding started right after birth? no yes Unk

- I. If not, at which day of life was breastfeeding started? ____ days of life not started prior to discharge
 II. Was breastfeeding delayed because COVID+ or suspected COVID+? no yes Unk

13. Type of feeding through first 48 hours	Fed by mother	Fed by alternate health care provider or family, who is NOT currently COVID-19 positive and is NOT a contact of a current COVID-19 case	Fed by alternate health care provider or family, who is either currently COVID-19 positive or a contact of a current COVID-19 case	Unknown
I. Breast fed	<input type="checkbox"/>	N/A	N/A	<input type="checkbox"/>
II. Expressed breast milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
III. Breast milk substitute – formula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV. Donor milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
V. Intravenous and/or TPN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INFANT MEDICATIONS

14. Medications given to infant (not including those administered in NICU, complete NICU information form):

- I. Erythromycin (eye prophylaxis): no yes unknown
 II. Vitamin K: no yes unknown
 III. Other no yes unknown -If yes, specify _____ Indication _____
 IV. Other no yes unknown - If yes, specify _____ Indication _____
 V. Other no yes unknown -If yes, specify _____ Indication _____

General Comments: _____

NICU INFORMATION

1. Was there a NICU Admission no, skip section yes, go to '2'
2. If non-singleton delivery, information below is for: N/a Baby A Baby B Baby C
3. NICU admission date (dd.mmm.yyyy) _____ 4. NICU discharge date (dd.mmm.yyyy) _____
5. Levels of NICU care needed: Level I Level II Level III not sure
6. Name of NICU providing highest level of care _____
7. Any diagnoses given in NICU? yes no unknown
 - I. Respiratory system:

<input type="checkbox"/> Respiratory distress syndrome <input type="checkbox"/> Transient tachypnoea of newborn <input type="checkbox"/> Meconium aspiration syndrome <input type="checkbox"/> Bronchopulmonary dysplasia <input type="checkbox"/> Congenital pneumonia <input type="checkbox"/> None	<input type="checkbox"/> Ventilator-associated pneumonia <input type="checkbox"/> Pneumothorax <input type="checkbox"/> Pleural effusion <input type="checkbox"/> Others (please describe): _____
--	---
 - II. Cardiovascular system:

<input type="checkbox"/> Hypotension requiring inotropes/steroids <input type="checkbox"/> Persistent pulmonary hypertension <input type="checkbox"/> None	<input type="checkbox"/> Patent ductus arteriosus <input type="checkbox"/> Myocarditis <input type="checkbox"/> Others (please describe): _____
--	--
 - III. Gastrointestinal system:

<input type="checkbox"/> Spontaneous intestinal perforation <input type="checkbox"/> Cow's milk protein allergy <input type="checkbox"/> Cholestasis (Bc>20umol/L) <input type="checkbox"/> None	<input type="checkbox"/> Necrotising enterocolitis <input type="checkbox"/> Intestinal obstruction <input type="checkbox"/> Elevated ALT and/or AST <input type="checkbox"/> Others (please describe): _____
---	--
 - IV. Infection:

<input type="checkbox"/> Culture proven sepsis <input type="checkbox"/> None	<input type="checkbox"/> Urinary tract infection <input type="checkbox"/> Others (please describe): _____
---	---
 - V. Neurological system:

<input type="checkbox"/> Intraventricular haemorrhage <input type="checkbox"/> Neonatal seizure <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> None	<input type="checkbox"/> Periventricular leucomalacia <input type="checkbox"/> Hypoxic-ischemic encephalopathy <input type="checkbox"/> Others (please describe): _____
---	--

VI. Hematological system:

- Thrombocytopenia (PLT<100x10⁹/L)
 None

- Leukopenia (WBC<5x10⁹/L)
 Others (please describe):

8. Care requirement at NICU

I. Respiratory system? yes no unknown

Invasive Mechanical ventilation If yes, duration (days) _____

Non-invasive ventilation If yes, duration (days) _____

Surfactant use If yes, number of doses _____

Use of inhaled nitric oxide If yes, duration (days) _____

II. Cardiovascular system? yes no unknown

ECMO (VA or VV) If yes, duration (days) _____

III. Gastrointestinal system? yes no unknown

Parenteral nutrition If yes, duration (days) _____

Surgery If yes, please describe: _____

IV. Neurological system? yes no unknown

Therapeutic hypothermia

EEG

Lumbar puncture for any reason If yes, key findings: _____

V. Imaging? yes no unknown

Chest x-ray If yes, key findings: _____

Ultrasound brain If yes, key findings: _____

MRI brain If yes, key findings: _____

9. Discharged from NICU to: home hospital other, specify _____ Unknown

INFANT MEDICATIONS IN NICU

10. Medications given to infant in NICU:

I. Erythromycin (eye prophylaxis): no yes unknown

II. Vitamin K: no yes unknown

III. Other no yes unknown -If yes, specify _____ Indication _____

IV. Other no yes unknown - If yes, specify _____ Indication _____

V. Other no yes unknown -If yes, specify _____ Indication _____

General Comments: _____

INFANT SARS-COV-2 TESTING**NOTE:** Update with all infant SARS-CoV-2 test resultsWas at least one SARS-COV-2 Lab test done in infant? Yes No Unk1. If non-singleton delivery, information below is for: N/a Baby A Baby B Baby C

2. Specimen	Collection Date & Time (dd.mmm.yyyy/hh:mm)	Lab Report Date (dd.mmm.yyyy)	Test	Result
<input type="checkbox"/> Nasopharyngeal swab #1	Date: Time:		PCR	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown
<input type="checkbox"/> Nasopharyngeal swab #2	Date: Time:		PCR	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown
<input type="checkbox"/> Nasopharyngeal swab #3	Date: Time:		PCR	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown
<input type="checkbox"/> Throat swab	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown
<input type="checkbox"/> Serology – IgM	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown
<input type="checkbox"/> Serology – IgG	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown
<input type="checkbox"/> Cord blood testing - IgM	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown
<input type="checkbox"/> Cord blood testing- IgG	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown
<input type="checkbox"/> Other testing, if clinically indicated: _____	Date: Time:			<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Indeterminate <input type="checkbox"/> Pending <input type="checkbox"/> Unknown

POSTPARTUM (6-8 WEEKS) DATA COLLECTION FORMS

POSTPARTUM FOLLOW-UP (6-8 WEEKS) – MATERNAL INFORMATION

1. Date (records current to, dd.mm.yyyy): _____

2. COVID Symptoms Postpartum (6-8 weeks) <input type="checkbox"/> no- asymptomatic <input type="checkbox"/> yes <input type="checkbox"/> unk		
3. Date of onset (dd.mmm.yyyy) _____		
I. Fever <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk <input type="checkbox"/> < 38°C <input type="checkbox"/> 38-39°C <input type="checkbox"/> >39°C <input type="checkbox"/> Unk	II. Cough <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	III. Headache <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
IV. Shortness of breath <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	V. Runny nose <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	VI. Muscle pain/myalgia <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
VII. Anorexia (loss of appetite) <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	VIII. Diarrhea <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	IX. Vomiting <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
X. Malaise <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XI. Fatigue <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XII. Anosmia or ageusia (loss of smell or taste): <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
XIII. Sore throat <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XIV. Sputum production <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XV. Nausea <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk
XVI. Non-specific respiratory symptoms <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XVII. Other Sx: _____ <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk	XVIII. Other Sx: _____ <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> unk

4. Any maternal health issues since delivery?*: _____

- No
 Postpartum depression
 Wound infection
 Postpartum preeclampsia
 Endometritis
 Other, describe: _____
 Unknown

NOTES:

*Please update the SARS-COV-2 HISTORY, MATERNAL TESTING, SYMPTOMS, TREATMENTS, & HOSPITALIZATIONS THROUGH FOLLOW-UP form as applicable: COVID symptoms (pages 5), complications (page 6), imaging (pages 6-7), treatments (page 8)

**Record maternal COVID-19 medications since discharge (or last report if home birth) below

***If additional infant SARS-CoV-2 testing or maternal SARS-CoV-2 testing is done, please update SARS-CoV-2 DCFs on the maternal testing forms and the infant testing forms

Postpartum Medications for COVID Since Discharge (or last report if home birth) - Maternal

NOTE: Record other medications on General Medications form

OVER THE COUNTER MEDICATIONS: <input type="checkbox"/> No over the counter medications <input type="checkbox"/> Unknown			
<p>1. <input type="checkbox"/> OTC meds (check all taken)</p> <p><input type="checkbox"/> Acetaminophen (Tylenol)</p> <p><input type="checkbox"/> NSAIDS</p> <p><input type="checkbox"/> Acetylsalicylic acid (Aspirin)</p> <p><input type="checkbox"/> Ibuprofen (Advil, Motrin, others)</p> <p><input type="checkbox"/> Naproxen (Aleve, Naprosyn, others)</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other: _____</p>			
PRESCRIPTION MEDICATIONS: <input type="checkbox"/> No prescription medications <input type="checkbox"/> Unknown			
<p>2. <input type="checkbox"/> Corticosteroids (check all taken)</p> <p><input type="checkbox"/> Dexamethasone</p> <p><input type="checkbox"/> Other, specify _____</p> <p><input type="checkbox"/> Other, specify _____</p>	<p><input type="checkbox"/> Clinical trial?</p> <p><input type="checkbox"/> Clinical trial?</p> <p><input type="checkbox"/> Clinical trial?</p>	<p>Dose:</p> <p>Dose:</p> <p>Dose:</p>	<p>Duration:</p> <p>Duration:</p> <p>Duration:</p>
<p>3. <input type="checkbox"/> Chloroquine. If yes, describe circumstance:</p>	<p><input type="checkbox"/> Clinical trial?</p>	<p>Dose:</p>	<p>Duration:</p>
<p>4. <input type="checkbox"/> Hydroxychloroquine. If yes, describe circumstance:</p>	<p><input type="checkbox"/> Clinical trial?</p>	<p>Dose:</p>	<p>Duration:</p>
<p>5. <input type="checkbox"/> Colchicine</p>	<p><input type="checkbox"/> Clinical trial?</p>	<p>Dose:</p>	<p>Duration:</p>

<p>6. <input type="checkbox"/> Antiviral (check all taken)</p> <p><input type="checkbox"/> Kaletra (Lopinavir/Ritonavir)</p> <p><input type="checkbox"/> Remdesivir</p> <p><input type="checkbox"/> Other, specify _____</p> <p><input type="checkbox"/> Other, specify _____</p>	<p><input type="checkbox"/> Clinical trial?</p> <p><input type="checkbox"/> Clinical trial?</p> <p><input type="checkbox"/> Clinical trial?</p> <p><input type="checkbox"/> Clinical trial?</p>	<p>Dose:</p> <p>Dose:</p> <p>Dose:</p> <p>Dose:</p>	<p>Duration:</p> <p>Duration:</p> <p>Duration:</p> <p>Duration:</p>
<p>7. <input type="checkbox"/> Antibiotics (check all taken)</p> <p><input type="checkbox"/> Specify _____</p> <p><input type="checkbox"/> Specify _____</p>	<p><input type="checkbox"/> Clinical trial?</p> <p><input type="checkbox"/> Clinical trial?</p>	<p>Dose:</p> <p>Dose:</p>	<p>Duration:</p> <p>Duration:</p>
<p>8. <input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> Clinical trial?</p>	<p>Dose:</p>	<p>Duration:</p>
<p>9. <input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> Clinical trial?</p>	<p>Dose:</p>	<p>Duration:</p>
<p>10. <input type="checkbox"/> Other _____</p>	<p><input type="checkbox"/> Clinical trial?</p>	<p>Dose:</p>	<p>Duration:</p>
<p>NATURAL HEALTH PRODUCTS FOR COVID: <input type="checkbox"/> No natural health products <input type="checkbox"/> Unknown</p>			
<p>11. <input type="checkbox"/> Natural health products</p>	<p><input type="checkbox"/> Specify _____</p> <p><input type="checkbox"/> Specify _____</p> <p><input type="checkbox"/> Specify _____</p> <p><input type="checkbox"/> Specify _____</p>		

General Comments: _____

POSTPARTUM FOLLOW-UP (6-8 WEEKS) – INFANT INFORMATION

1. If non-singleton delivery, information below is for: N/a Baby A Baby B Baby C
2. Any infant health events / issues since discharge (last report for home births without admission):
- I. Poor weight gain Unk no yes, describe: _____
- II. Seizures/ on antiepileptic medications Unk no yes, describe: _____
- III. Bronchiolitis Unk no yes, describe: _____
- IV. Constipation Unk no yes, describe: _____
- V. Pneumonia Unk no yes, describe: _____
- VI. Rehospitalization Unk no yes, describe: _____
- VII. Acquire or relapse of COVID after discharge? Unk no yes, describe: _____
- VIII. Infant death Unk no yes If yes, please complete infant death form
- IX. Other Unk no yes, describe: _____

INFANT FEEDING

3. Type of feeding to date	Fed by mother	Fed by alternate health care provider or family, who is NOT currently COVID-19 positive and is NOT a contact of a current COVID-19 case	Fed by alternate health care provider or family, who is either currently COVID-19 positive or a contact of a current COVID-19 case	Unknown
I. Breast fed	<input type="checkbox"/>	N/A	N/A	<input type="checkbox"/>
II. Expressed breast milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
III. Breast milk substitute – formula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV. Donor milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
V. Intravenous and/or TPN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INFANT MEDICATIONS

4. Medications given to infant: no yes unknown If yes, complete below

I. Specify _____ Indication _____

II. Specify _____ Indication _____

III. Specify _____ Indication _____

IV. Specify _____ Indication _____

V. Specify _____ Indication _____

General Comments: _____

1 YEAR INFANT FOLLOW-UP DATA COLLECTION FORMS

ONE YEAR INFANT FOLLOW-UP INFORMATION

1. Date (records current to, dd.mm.yyyy): _____
2. If non-singleton delivery, information below is for: N/a Baby A Baby B Baby C
3. Any infant health events / issues since 6-8 week follow-up):
- | | | | |
|---|------------------------------|-----------------------------|---|
| I. Poor weight gain / failure-to-thrive | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| II. Anaphylaxis | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| III. Allergic rhinitis | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| IV. Kawasaki disease | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| V. Asthma | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| VI. Need for home oxygen for any duration | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| VII. Diabetes mellitus | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| VIII. Hypothyroidism | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| IX. Renal failure requiring replacement therapy | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| X. Hypertension | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| XI. Glomerulonephritis | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| XII. Urinary tract infection | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| XIII. Culture proven bacteremia | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| XIV. Meningitis | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| XV. Otitis media | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| XVI. Acute bronchitis | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| XVII. Acute bronchiolitis | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| XVIII. Pneumonia, any organism | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |
| XIX. Upper respiratory infection | <input type="checkbox"/> Unk | <input type="checkbox"/> no | <input type="checkbox"/> yes, describe: _____ |

- XX. Any infection caused by Escherichia coli Unk no yes, describe: _____
- XXI. Any infection caused by Haemophilus influenzae Unk no yes, describe: _____
- XXII. Any infection caused by Klebsiella pneumoniae Unk no yes, describe: _____
- XXIII. Any infection caused by Streptococcus Unk no yes, describe: _____
- XXIV. Any infection caused by Staphylococcus Unk no yes, describe: _____
- XXV. Enterovirus infection Unk no yes, describe: _____
- XXVI. Gastroenteritis Unk no yes, describe: _____
- XXVII. Constipation Unk no yes, describe: _____
- XXVIII. Hand-Foot-and-Mouth Disease Unk no yes, describe: _____
- XXIX. Herpes simplex Unk no yes, describe: _____
- XXX. Respiratory syncytical virus Unk no yes, describe: _____
- XXXI. Varicella (chickenpox) Unk no yes, describe: _____
- XXXII. Seizures/ on antiepileptic medications Unk no yes, describe: _____
- XXXIII. Rehospitalization Unk no yes, describe: _____
- XXXIV. Acquire or relapse of COVID after 6-8 week follow-up? Unk no yes, describe: _____
- XXXV. Infant death Unk no yes If yes, please complete infant death form
- XXXVI. Other Unk no yes, describe: _____

INFANT FEEDING

4. Type of feeding to date	Fed by mother	Fed by alternate health care provider or family, who is NOT currently COVID-19 positive and is NOT a contact of a current COVID-19 case	Fed by alternate health care provider or family, who is either currently COVID-19 positive or a contact of a current COVID-19 case	Unknown
I. Breast fed	<input type="checkbox"/>	N/A	N/A	<input type="checkbox"/>
II. Expressed breast milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
III. Breast milk substitute – formula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV. Donor milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
V. Intravenous and/or TPN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INFANT MEDICATIONS**I. Antihistamine**

(Examples: Atarax (hydroxyzine); Reactine (cetirizine); Rupall (rupatadine); Blexten (bilastine))

Unk no yes

If yes, duration: <1 week 1-2 weeks
 3-4 weeks >4 weeks

Specify: _____

II. Beta-agonists or inhaled bronchodilators

(Examples: Ventolin (salbutamol); Bricanyl (terbutaline))

Unk no yes

If yes, duration: <1 week 1-2 weeks
 3-4 weeks >4 weeks

Specify: _____

III. Inhaled corticosteroids

Unk no yes

If yes, duration: <1 week 1-2 weeks
 3-4 weeks >4 weeks

Specify: _____

- IV. **Intranasal corticosteroids** Unk no yes
 If yes, duration: <1 week 1-2 weeks
 3-4 weeks >4 weeks
Specify: _____
- V. **Systemic corticosteroids** Unk no yes
 (Examples: dexamethasone, prednisone, hydrocortisone)
 If yes, duration: <1 week 1-2 weeks
 3-4 weeks >4 weeks
Specify: _____
- VI. **Any medications for endocrine-related disorders** Unk no yes
 (Examples: Desmopressin, Diazoxide, Glucagon, Growth hormone, Insulin, Lupron, Octreotide, Testosterone, Thyroxine)
 If yes, duration: <1 week 1-2 weeks
 3-4 weeks >4 weeks
Specify: _____
- VII. Any anti-hypertensive medication Unk no yes
 If yes, duration: <1 week 1-2 weeks
 3-4 weeks >4 weeks
Specify: _____
- VIII. Any antibiotics Unk no yes
 If yes, duration: <1 week 1-2 weeks
 3-4 weeks >4 weeks
Specify: _____
- IX. Any probiotics (prescribed or over-the-counter) Unk no yes
 If yes, duration: <1 week 1-2 weeks
 3-4 weeks >4 weeks
Specify: _____
- X. Other 1 Unk no yes
 If yes, duration: <1 week 1-2 weeks
 3-4 weeks >4 weeks
Specify: _____
- XI. Other 2 Unk no yes
 If yes, duration: <1 week 1-2 weeks
 3-4 weeks >4 weeks
Specify: _____

General Comments: _____

MATERNAL DEATH**NOTE: Please complete this form in the event of a maternal death.**

1. Date of death (dd.mmm.yyyy)	
2. Probable cause of death as per clinical report (Describe):	
3. Autopsy completed? <input type="checkbox"/> no <input type="checkbox"/> yes	
4. Examination date (dd.mmm.yyyy):	
5. Examination findings:	
6. Pathologic diagnoses:	
7. Cause of death as per autopsy report:	
8. General Comments	

INFANT DEATH**NOTE: Please complete this form in the event of an infant death.**1. If multiples, this form refers to: N/a Baby A Baby B Baby C

2. Postnatal age in calendar days (Age of infant in hours, if <24 hours, add "h" at the end):

3. Probable cause of death as per clinical report (Describe):

4. Autopsy completed? no yes5. Examination date
(dd.mmm.yyyy):

6. Examination findings:

7. Pathologic diagnoses:

8. Cause of death as per
autopsy report

9. General Comments

GENERAL MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER) & SUPPLEMENTS FORM - MATERNAL

NOTES:

- For any medications/supplements taken related to COVID, in pregnancy, intrapartum or 6-8 weeks postpartum, complete respective forms above. For all other medications (maternal) complete this table.
- For any medications/supplements given to infant, either related to COVID, in the case of a NICU admission, or generally, please complete in respective sections above.

I. MEDICATIONS / SUPPLEMENTS DURING PREGNANCY	
<input type="checkbox"/> No medications / supplements taken at any time during pregnancy, other than for COVID as indicated on above forms	
<input type="checkbox"/> Unknown	
Specify Medication / Supplement	Indication (Reason Given)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
II. MEDICATIONS / SUPPLEMENTS INTRAPARTUM (DURING LABOUR UNTIL DELIVERY)	
<input type="checkbox"/> No medications / supplements taken at any time intrapartum, other than for COVID as indicated on above forms	
<input type="checkbox"/> Unknown	
Specify Medication / Supplement	Indication (Reason Given)
1.	
2.	
3.	
4.	

5.	
6.	
7.	
8.	
9.	
10.	

III. MEDICATIONS / SUPPLEMENTS POSTPARTUM UNTIL 6-8 WEEKS FOLLOW-UP

- No medications / supplements taken at any time postpartum until 6-8 weeks follow-up, other than for COVID as indicated on above forms
- Unknown

Specify Medication / Supplement	Indication (Reason Given)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

General Comments: _____
