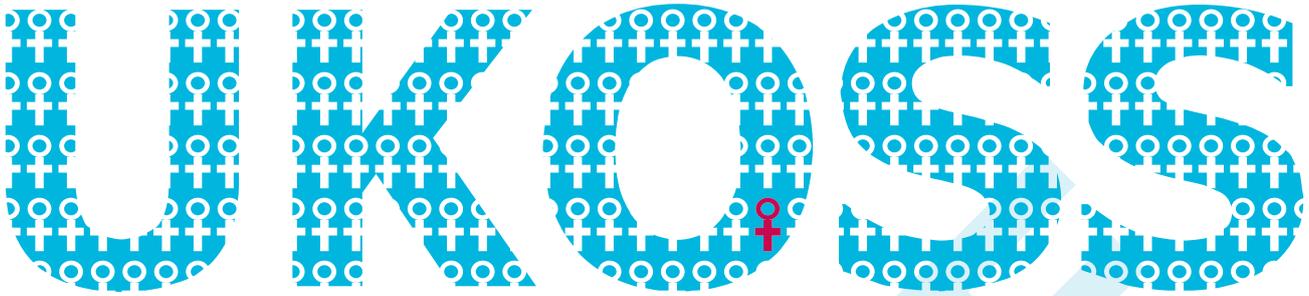


ID Number:



UK Obstetric Surveillance System

Influenza Study 04/09

Data Collection Form - CASE

Please report all pregnant women admitted on or after 1st September 2009

and before 1st February 2010

Case Definition:

Any woman admitted to hospital with confirmed H1N1v influenza infection in pregnancy.

Please return the completed form to:

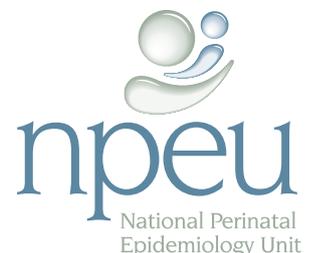
UKOSS
National Perinatal Epidemiology Unit
University of Oxford
Old Road Campus
Oxford
OX3 7LF



Royal College of
Obstetricians and
Gynaecologists

Fax: 01865 289701
Phone: 01865 289714

Case reported in: _____



Instructions

1. Please do not enter any personally identifiable information (e.g. name, address or hospital number) on this form.
2. Please record the ID number from the front of this form against the woman's name on the Clinician's Section of the blue card retained in the UKOSS folder.
3. Fill in the form using the information available in the woman's case notes.
4. Tick the boxes as appropriate. If you require any additional space to answer a question please use the space provided in section 7.
5. Please complete all dates in the format DD/MM/YY, and all times using the 24hr clock e.g. 18.37
6. If codes or examples are required, some lists (not exhaustive) are included on the back page of the form.
7. If the woman has not yet delivered, please complete the form as far as you are able, excluding delivery and outcome information, and return to the UKOSS Administrator. We will send these sections again for you to complete two weeks after the woman's expected date of delivery.
8. **If you do not know the answers to some questions, please indicate this in section 7.**
9. If you encounter any problems with completing the form please contact the UKOSS Administrator or use the space in section 7 to describe the problem.

Section 1: Woman's details

1.1 Year of birth

1.2 Ethnic group^{1*} (enter code, please see back cover for guidance)

1.3 Marital status

single married cohabiting

1.4 Was the woman in paid employment at booking?

Yes No

If Yes, what is her occupation

If No, what is her partner's (if any) occupation

1.5 Height at booking

 cm

1.6 Weight at booking

 . kg

1.7 Smoking status

never gave up prior to pregnancy
current gave up during pregnancy

Section 2: Previous Obstetric History

2.1 Gravidity

Number of previous completed pregnancies beyond 24 weeks

Number of previous pregnancies less than 24 weeks

If no previous pregnancies, please go to section 3

*For guidance please see back cover

2.2 Did the woman have any previous pregnancy problems?^{2*}

Yes No

If Yes, please specify _____

Section 3: Previous Medical History

3.1 Does the woman have asthma requiring regular inhaled or oral steroids? Yes No

3.2 Has the woman had any other previous or pre-existing medical problems?^{3*} Yes No

If Yes, please specify _____

3.3 Has the woman been immunised against H1N1v? Yes No

If Yes, please give dates immunised

/ /

/ /

Section 4: This Pregnancy

4.1 Final Estimated Date of Delivery (EDD)^{4*} / /

4.2 Was this pregnancy a multiple pregnancy? Yes No

If Yes, specify number of fetuses

4.3 Were there problems in this pregnancy?^{2*} Yes No

If Yes, please specify _____

4.4 Was the woman admitted to hospital? Yes No

If Yes, please give date of admission

/ /

Diagnosis of Influenza A H1N1v

4.5 Please indicate presenting symptoms and date of onset in the table below

Symptom	Tick if Yes	If Yes, give date of onset
Fever	<input type="checkbox"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Cough	<input type="checkbox"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Sore throat	<input type="checkbox"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Headache	<input type="checkbox"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Tiredness/lethargy	<input type="checkbox"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Limb or joint pain	<input type="checkbox"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Diarrhoea	<input type="checkbox"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Breathlessness	<input type="checkbox"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Vomiting	<input type="checkbox"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Rhinorrhoea	<input type="checkbox"/>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>

*For guidance please see back cover

4.6 Has virological testing for H1N1v been carried out? Yes No

If Yes, did this confirm the diagnosis? Yes No

If Yes, please specify

Type identified _____

Sample source _____

Date of first positive test

If No, what was the final diagnosis? _____

4.7 Was this a clinical diagnosis only? Yes No

Therapy

4.8 Were anti-viral drugs used for H1N1v infection? Yes No

If Yes, please specify

First Agent

Second Agent

Agent used _____

Date treatment started

Date treatment stopped

Dose _____

Route _____

Schedule (e.g. bd) _____

Adverse effects _____

4.9 Were other drugs used during pregnancy? Yes No

If Yes, please specify _____

4.10 Were steroids given to enhance fetal lung maturation? Yes No

If Yes, please specify

First Agent

Second Agent

Agent used _____

Date given

Dose _____

4.11 Did this woman receive ECMO? Yes No

4.12 Was this woman transferred to another hospital? Yes No

If Yes, please indicate name of hospital _____

Section 5: Delivery

5.1 Did this woman have a miscarriage?

Yes No

If Yes, please specify date

/ /

5.2 Did this woman have a termination of pregnancy?

Yes No

If Yes, please specify date

/ /

Was the pregnancy terminated due to a congenital malformation?

Yes No

If Yes, please specify _____

5.3 Is this woman still undelivered?

Yes No

If Yes, Will she be receiving the rest of her antenatal care from your hospital?

Yes No

If No, please indicate name of hospital providing future care

If still undelivered, please complete section 6a and then go to section 7.

If the woman has delivered, please continue.

5.4 Was delivery induced?

Yes No

If Yes, please state indication _____

Was vaginal prostaglandin used?

Yes No

5.5 Did the woman labour?

Yes No

If Yes, please give date and time of onset of labour

/ / :
24hr

5.6 Was delivery by caesarean section?

Yes No

If Yes, please state:

Grade of urgency^{5*}

Indication for caesarean section _____

Method of anaesthesia:

Regional

General anaesthetic

Section 6: Outcomes

Section 6a: Woman

6a.1 Was the woman admitted to ITU?

Yes No

If Yes, please specify

Duration of stay

days

Or Tick if woman is still in ITU

Or Tick if woman was transferred to another hospital

6a.2 Did any other major maternal morbidity occur?^{6*}

Yes No

If Yes, please specify _____

6a.3 What was the woman's date of discharge after her admission for flu?

/ /

6a.4 Did the woman die?

Yes No

If Yes, please specify date and time of death

/ / :
24hr

What was the primary cause of death as stated on the death certificate?

(Please state if not known.) _____

Section 6b: Section 6b: Infant 1

NB: If more than one infant, for each additional infant, please photocopy the infant section of the form (before filling it in) and attach extra sheet(s) or download additional forms from the website: www.npeu.ox.ac.uk/ukoss

6b.1 Date and time of delivery

/ / :
24hr

6b.2 Mode of delivery

Spontaneous vaginal

Ventouse

Lift-out forceps

Rotational forceps

Breech

Pre-labour caesarean section

Caesarean section after onset of labour

6b.3 Birthweight

g

6b.4 Was the infant stillborn?

Yes No

If Yes, please go to section 7.

6b.5 5 min Apgar

6b.6 Was the infant admitted to the neonatal unit?

Yes No

If Yes, please specify

Duration of stay

days

Or Tick if infant is still in neonatal unit

Or Tick if infant was transferred to another hospital

6b.7 Did any other major infant complications occur?^{7*}

Yes No

If Yes, please specify _____

Definitions

1. UK Census Coding for ethnic group

WHITE

01. British
02. Irish
03. Any other white background

MIXED

04. White and black Caribbean
05. White and black African
06. White and Asian
07. Any other mixed background

ASIAN OR ASIAN BRITISH

08. Indian
09. Pakistani
10. Bangladeshi
11. Any other Asian background

BLACK OR BLACK BRITISH

12. Caribbean
13. African
14. Any other black background

CHINESE OR OTHER ETHNIC GROUP

15. Chinese
16. Any other ethnic group

2. Previous or current pregnancy problems, including:

Thrombotic event
Amniotic fluid embolism
Eclampsia
3 or more miscarriages
Preterm birth or mid trimester loss
Neonatal death
Stillbirth
Baby with a major congenital abnormality
Small for gestational age (SGA) infant
Large for gestational age (LGA) infant
Infant requiring intensive care
Puerperal psychosis
Placenta praevia
Gestational diabetes
Significant placental abruption
Post-partum haemorrhage requiring transfusion
Surgical procedure in pregnancy
Hyperemesis requiring admission
Dehydration requiring admission
Ovarian hyperstimulation syndrome
Severe infection e.g. pyelonephritis

3. Previous or pre-existing maternal medical problems, including:

Cardiac disease (congenital or acquired)
Renal disease
Endocrine disorders e.g. hypo or hyperthyroidism
Psychiatric disorders
Haematological disorders e.g. sickle cell disease, diagnosed thrombophilia
Inflammatory disorders e.g. inflammatory bowel disease
Autoimmune diseases
Cancer
HIV

4. Estimated date of delivery (EDD):

Use the best estimate (ultrasound scan or date of last menstrual period) based on a 40 week gestation

5. RCA/RCOG/CEMACH/CNST Classification for urgency of caesarean section:

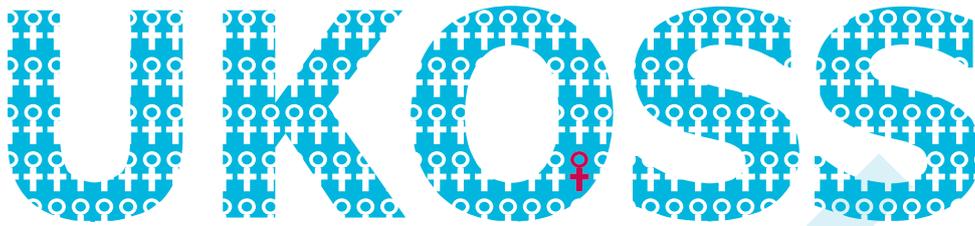
1. Immediate threat to life of woman or fetus
2. Maternal or fetal compromise which is not immediately life-threatening
3. Needing early delivery but no maternal or fetal compromise
4. At a time to suit the woman and maternity team

6. Major maternal medical complications, including:

Persistent vegetative state
Cardiac arrest
Cerebrovascular accident
Adult respiratory distress syndrome
Disseminated intravascular coagulopathy
HELLP
Pulmonary oedema
Secondary infection e.g. pneumonia
Renal failure
Thrombotic event
Septicaemia
Required ventilation

7. Fetal/infant complications, including:

Respiratory distress syndrome
Intraventricular haemorrhage
Necrotising enterocolitis
Neonatal encephalopathy
Chronic lung disease
Severe jaundice requiring phototherapy
Major congenital anomaly
Severe infection e.g. septicaemia, meningitis
Exchange transfusion



UK Obstetric Surveillance System

H1N1v (“swine flu”) in Pregnancy

Case ID:

Thank you for reporting the above case to UKOSS.

Now please make a note of the following details to keep in the UKOSS folder in case of future queries.

Patient's name: _____

Patient's Hospital number: _____

Patient's year of birth: _____

EDD: _____

Case reported by: _____

Date reported: _____

Please keep this sheet with these identifying details,
do not send them to UKOSS.

Return the rest of the form to the address given on the front.