CASE RECORD FORM – COVID-19 IN PREGNANCY - PAKISTAN

Adapted from WHO PREGNANCY MODULE FOR COVID-19 CASE RECORD FORM RAPID version 23MAR2020

PARTICIPANT ID/ MR NO I___I I___I I___I I___I I___I -- I___I I___I I___I I___I

HOSPITAL NAME _____

PREGNANCY MODULE (Form 1): complete on admission/enrolment

Is Subject Pregnant or recently delivered within 42 days from onset of symptoms?

☐ Yes ☐ No ☐Unknown

If "yes" Answer the following – otherwise skip this form.

Q1. STATUS UPON ADMISSION	
Pregnant not in labour	☐
Pregnant in labour	☐
Postpartum [days]*	☐ [days] Breastfeeding? ☐ YES ☐ NO
Post-abortion, miscarriage	☐
Number of foetuses	☐Singleton ☐Twin ☐Triplet ☐Other [number] ☐ Unknown
Best estimate of gestational age in completed weeks	[_W_][_W_] weeks

* This form does not need to be completed if symptoms of COVID-19 started more than 42 days post-partum

Q2. ABORTION OR MISCARRIAGE prior to admission ☐ YES ☐ NO *If "no" skip to Q3*	
Date of induced abortion or spontaneous abortion/miscarriage?	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐ Date not available
Were symptoms of COVID-19 disease present at the time?	☐ YES ☐ NO ☐ UNKNOWN

Q3. OBSTETRIC HISTORY	
Number of previous pregnancies beyond 24 weeks gestation [number]	
Please tick ALL which apply to ALL previous deliveries:	
Preterm birth (<37 weeks' gestation)	☐ YES ☐ NO ☐ UNKNOWN
Congenital anomaly	☐ YES ☐ NO ☐ UNKNOWN
Stillborn	☐ YES ☐ NO ☐ UNKNOWN
Neonatal death (0-6 days)	☐ YES (day:) ☐ NO ☐ UNKNOWN
Weight < 2.5kg	☐ YES ☐ NO ☐ UNKNOWN
Weight > 4.5kg	☐ YES ☐ NO ☐ UNKNOWN

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Q4. SMOKING, DRUGS– RISK FACTORS	
Smoking/sheesha during this/last pregnancy	☐ YES ☐ NO ☐ UNKNOWN
Illicit and recreational drug use during this/last pregnancy	☐ YES ☐ NO ☐ UNKNOWN

Q5. MEDICATIONS DURING THIS PREGNANCY (Prior to onset of current illness episode)	
Fever or pain treatment	**Acetaminophen/paracetamol** ☐YES ☐NO ☐UNKNOWN
	NSAID/s ☐YES ☐NO ☐UNKNOWN
	Other/s (specify): [ ]
Anticonvulsants	☐YES ☐NO ☐UNKNOWN **If yes, specify generic name: [ ]**
Anti-nausea	☐YES ☐NO ☐UNKNOWN **If yes, specify generic name: [ ]**
Prenatal vitamins and micronutrients	☐Yes ☐No ☐Unknown **If yes, specify (e.g. folic acid): [ ]**
Antivirals	☐YES ☐NO ☐UNKNOWN **If yes, specify generic name: [ ]**
Antibiotics	☐YES ☐NO ☐UNKNOWN **If yes, specify generic name: [ ]**
Any other medicine	☐YES ☐NO ☐UNKNOWN **If yes, specify generic name: [ ]**

Q6. SIGNS AND SYMPTOMS ON ADMISSION	
Vaginal watery discharge	☐ YES ☐ NO ☐ UNKNOWN
Vaginal bleeding	☐ YES ☐ NO ☐ UNKNOWN
Headaches	☐ YES ☐ NO ☐ UNKNOWN
Vision changes	☐ YES ☐ NO ☐ UNKNOWN
Right upper quadrant (abdominal) pain	☐ YES ☐ NO ☐ UNKNOWN
Decreased or no fetal movement	☐ YES ☐ NO ☐ UNKNOWN
Uterine contractions	☐ YES ☐ NO ☐ UNKNOWN
Seizures	☐ YES ☐ NO ☐ UNKNOWN

Q7. FETAL HEART RATE (first available data at presentation/admission)	
Fetal heart rate	**(FHR):** [_ _][_ _][_ _] beats/min

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PREGNANCY MODULE (Form 2): follow-up

(For Daily Assessment, frequency of completion determined by available resources)

Date of follow up [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Q1. FETAL HEART RATE (Follow up)	
Fetal heart rate (record most abnormal value between 00:00 to 24:00)	**(FHR):** [_ _][_ _][_ _] beats/min

Q2. TREATMENT DURING HOSPITALISATION At ANY time during hospitalisation, did the patient receive/undergo:	
Tocolysis	☐ YES ☐ NO ☐ UNKNOWN
Induction of labour	☐ YES ☐ NO ☐ UNKNOWN
Blood transfusion	☐ YES ☐ NO ☐ UNKNOWN
Surgical/Medical management of abortion/post abortion care	☐ YES ☐ NO ☐ UNKNOWN
Management of PROM (corticiosteroids)	☐ YES ☐ NO ☐ UNKNOWN
Management for COVID-19	☐ YES ☐ NO ☐ UNKNOWN
If yes, what treatment was given:	☐ Symptomatic treatment ☐ Oxygen therapy ☐ ICU care ☐ On ventilator

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PREGNANCY MODULE (Form 3): complete at discharge/death

Q1. DELIVERY, PREGNANCY AND MATERNAL OUTCOMES		
Date & Time of delivery (during admission or not)	☐Yes ☐ No **If yes, date:** [_D_][_ D_]/[_ M_][_ M _]/[_2_][_0 _][_Y _][_Y _] **Time:** [__ __ : __ __] ☐ AM ☐ PM	
If delivered during admission, specify mode of delivery:	☐ Spontaneous vaginal delivery ☐ Assisted vaginal delivery ☐ Caesarean section	
Onset of labour	☐ Spontaneous ☐ Induced ☐ Cesarean section before labour ☐ Unknown	
Amniotic fluid at delivery	☐ Clear ☐ Meconium stained ☐ Unknown	
Other maternal outcomes/pregnancy complications	Gestational diabetes	☐ YES ☐ NO ☐ UNKNOWN
	Gestational hypertension	☐ YES ☐ NO ☐ UNKNOWN
	Anemia (Hb < 11 g/dL)	☐ YES ☐ NO ☐ UNKNOWN
	Hyperemesis	☐ YES ☐ NO ☐ UNKNOWN
	Intrauterine growth restriction	☐ YES ☐ NO ☐ UNKNOWN
	Placenta previa	☐ YES ☐ NO ☐ UNKNOWN
	If yes, which type:	☐ increta ☐ accreta ☐ percreta
	Bacterial infection prior to hospital visit	☐ YES ☐ NO ☐ UNKNOWN
	Pre-eclampsia/eclampsia	☐ YES ☐ NO ☐ UNKNOWN
	Placental abruption	☐ YES ☐ NO ☐ UNKNOWN
	Preterm contractions	☐ YES ☐ NO ☐ UNKNOWN
	Preterm labor	☐ YES ☐ NO ☐ UNKNOWN
	Preterm rupture of membranes	☐ YES ☐ NO ☐ UNKNOWN
	Early or mid term miscarriage	☐ YES ☐ NO ☐ UNKNOWN
	Haemorrhage	☐ YES ☐ NO ☐ UNKNOWN

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	If haemorrhage, which type:	☐ Antepartum/intrapartum ☐ Postpartum hemorrhage ☐ Abortion-related
	Retained placenta/POC	☐ YES ☐ NO ☐ UNKNOWN
	Thromboembolic disease	☐ YES ☐ NO ☐ UNKNOWN
	Anesthestic complication	☐ YES ☐ NO ☐ UNKNOWN
	Postpartum depression	☐ YES ☐ NO ☐ UNKNOWN

Q2. POSTPARTUM/POST ABORTION CONTRACEPTION	
Counseling on postpartum/postabortion contraception	☐ YES ☐ NO ☐ UNKNOWN
Postpartum/postabortion contraception accepted If yes, which contraceptive method chosen:	☐ YES ☐ NO ☐ UNKNOWN ☐ Oral Pills ☐ Injectable ☐ ECP ☐ IUCD ☐ Implant ☐ Surgical method
If “no” (refusal), what advice given to the woman on contraception?	Plz specify _____

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Q3. PREGNANCY STATUS AT DISCHARGE	
Pregnancy status/outcome	☐ Undelivered ☐ Threatened abortion ☐ Spontaneous abortion ☐ Incomplete abortion ☐ Induced abortion ☐ Missed abortion ☐ Macerated stillbirth ☐ Fresh stillbirth ☐ Livebirth
Maternal death **If yes, what was the primary cause of death?**	☐ Yes ☐ No ☐ Abortion/ectopic pregnancy ☐ Hypertensive disorder ☐ Obstetric hemorrhage ☐ Obstetric related infection ☐ Other direct cause (other obstetric complications) ☐ Unanticipated complication of management (medical/surgical) ☐ Indirect cause ☐ Severe acute respiratory infection ☐ COVID-19 infection ☐ Unknown

Q4. Sample Collection **(Note: for each test which is conducted write the test description, date of collection and result)**				
Any sampling conducted? If so, please describe the test and the results	☐ Amniotic fluid	[_test description__]	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]]	[_____result_____]
	☐ Placenta	[_test description__]	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]]	[_____result_____]
	☐ Cord blood	[_test description__]	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]]	[_____result_____]
	☐ Vaginal swab	[_test description__]	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]]	[_____result_____]
	☐ Faeces/rectal	[_test description__]	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]]	[_____result_____]
	☐ Pregnancy tissue in the case of fetal demise / induced abortion	[_test description__]	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]]	[_____result_____]
	☐ Breastmilk	[_test description__]	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]]	[_____result_____]

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Q5. NEONATAL OUTCOMES	
Date of birth [DD/MM/YYYY] **Time of birth [e.g. 14:21]**	[_D_][_ D_]/[_ M_][_ M _]/[_2_][_0 _][_ Y _][_ Y _] [____:____] ☐ Not available
Participant ID/MR No of the mother:	[___][___][___][___][___]–[___][___][___][___] **–** [__Single digit Baby ID_]* ***complete one form per neonate**
COVID-19 lab test of foetus or neonate	☐ Performed ☐ Not performed ☐ Unknown If yes: [_sample collected__] [_test description__] [_date of collection__] [_____result_____]
Apgar score at 5 minutes	Score: [___][___] ☐ Not available
Gestational age	Weeks: [___][___] Days: [_____] ☐ Not available
Birth weight	Grams: [___][___][___][___] ☐ Not available
Vaccinations at birth	☐ YES ☐ NO ☐ UNKNOWN
Respiratory distress syndrome	☐ YES ☐ NO ☐ UNKNOWN
Neonatal outcome	☐ Discharged healthy ☐ Discharged with complications/sequelae Details: [_____] ☐ Clinical referral to specialist ward /other hospital Details: [_____] ☐ Death Date of death: [_D_][_ D_]/[_ M_][_ M _]/[_ Y _][_ Y _] ☐ Unknown
If neonate died, primary cause of death	☐ Preterm/low birth weight ☐ Birth asphyxia ☐ Infection ☐ Birth trauma ☐ Congenital/birth defects ☐ Other - Specify_____ ☐ Unknown
Any congenital anomalies	☐ Neural tube defects ☐ Microcephaly ☐ Congenital malformations of ear ☐ Congenital heart defects ☐ Orofacial clefts ☐ Congenital malformations of digestive system ☐ Congenital malformations of genital organs ☐ Abdominal wall defects ☐ Chromosomal abnormalities ☐ Reduction defects of upper and lower limbs ☐ Talipes equinovarus/clubfoot