

Case number:

PREGNANCY REPORT FORM

Sponsor: Médecins Sans Frontières	Protocol/Program n°:	Site n° (for studies) or country:
Initial report: <input type="checkbox"/>	Follow-up report: <input type="checkbox"/>	Date of report: ____ / ____ / ____ (dd/Mmm/yyyy)

Patient information (mother)

Patient n°: [Father <input type="checkbox"/> Mother <input type="checkbox"/>]	Mother initials:	Mother date of birth: ____ / ____ / ____ (dd/Mmm/yyyy)	Mother height: cm	Mother weight: kg
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Relevant drug(s) exposure before/during pregnancy

Drug name (INN)
Daily dose & route							
Batch number							
Treatment start date (dd/Mmm/yyyy)	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
Treatment stop date (dd/Mmm/yyyy)	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
Drug taken by	Father <input type="checkbox"/> / Mother <input type="checkbox"/>	Father <input type="checkbox"/> / Mother <input type="checkbox"/>	Father <input type="checkbox"/> / Mother <input type="checkbox"/>	Father <input type="checkbox"/> / Mother <input type="checkbox"/>	Father <input type="checkbox"/> / Mother <input type="checkbox"/>	Father <input type="checkbox"/> / Mother <input type="checkbox"/>	Father <input type="checkbox"/> / Mother <input type="checkbox"/>

Action taken in response to the pregnancy

Dosage maintained	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dose reduced	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
New daily dose							
On (dd/Mmm/yyyy)	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
Drug permanently withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On (dd/Mmm/yyyy)	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
Drug interrupted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
From (dd/Mmm/yyyy)	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
To (dd/Mmm/yyyy)	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
Not applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Pregnancy information

Date of 1 st day of last menstrual period	____ / ____ / ____ (dd/Mmm/yyyy)	Estimated date of delivery	____ / ____ / ____ (dd/Mmm/yyyy)
Pregnancy test	<input type="checkbox"/> Positive urine test Date: ____ / ____ / ____ (dd/Mmm/yyyy)	<input type="checkbox"/> Positive blood test Date: ____ / ____ / ____ (dd/Mmm/yyyy)	<input type="checkbox"/> Positive ultrasound Date: ____ / ____ / ____ (dd/Mmm/yyyy)

Pregnancy outcome

1. Did the patient experience any complication during pregnancy?	<input type="checkbox"/> Yes. Specify: <input type="checkbox"/> No
2. Did the patient give birth to (a) live infant(s)?	<input type="checkbox"/> Yes. Date of delivery (dd/Mmm/yyyy): ____ / ____ / ____ <input type="checkbox"/> No. Specify reason:
3. Was the infant normal at birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No. Specify abnormality and reason:
Additional comment on pregnancy/delivery	

Infant(s) information

Infant number	Infant sex	Infant length (cm)	Infant weight (g)	APGAR score	Exposure during breastfeeding	Comment
1	F <input type="checkbox"/> M <input type="checkbox"/>				Yes <input type="checkbox"/> No <input type="checkbox"/>	
2	F <input type="checkbox"/> M <input type="checkbox"/>				Yes <input type="checkbox"/> No <input type="checkbox"/>	
3	F <input type="checkbox"/> M <input type="checkbox"/>				Yes <input type="checkbox"/> No <input type="checkbox"/>	

Relevant medical history (with focus on relevant prior gynaecological/obstetric history)

Reporter

Name of reporter:	Role in trial/program:	Date of awareness: ____ / ____ / ____	Address: Email: Phone:	Date and signature: ____ / ____ / ____
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