Seasonal Influenza in Pregnancy
Study 05/16

Data Collection Form - CASE

Please report all pregnant women admitted on or after 1st November 2016
and before 1st November 2018

Case Definition:
Any woman admitted to hospital with confirmed influenza infection in pregnancy.

Please return the completed form to:
UKOSS
National Perinatal Epidemiology Unit
University of Oxford
Old Road Campus
Oxford
OX3 7LF
Fax: 01865 617775
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 table provided 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.

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**Section 1: Woman's details**

1.1 Year of birth

1.2 Ethnic group***(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

1.6 Weight at booking

1.7 Smoking status
- never
- gave up prior to pregnancy
- current
- gave up during pregnancy

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**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

2.2 Did the woman have any previous pregnancy problems?***(enter code, please see back cover for guidance)***

- Yes
- No

  If Yes, please specify ________________________________

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*For guidance please see back cover
**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?  
Yes ☐  No ☐  
If Yes, please specify ________________________________

3.3 Has the woman ever been immunised against influenza?  
Yes ☐  No ☐  
If Yes, please give details of the most recent immunisations (up to 4):

<table>
<thead>
<tr>
<th>Dates immunised</th>
<th>Was this seasonal influenza vaccine or pandemic-type vaccine?</th>
</tr>
</thead>
<tbody>
<tr>
<td>D M Y YMD</td>
<td>Seasonal ☐ Pandemic ☐</td>
</tr>
<tr>
<td>D M Y YMD</td>
<td>Seasonal ☐ Pandemic ☐</td>
</tr>
<tr>
<td>D M Y YMD</td>
<td>Seasonal ☐ Pandemic ☐</td>
</tr>
<tr>
<td>D M Y YMD</td>
<td>Seasonal ☐ Pandemic ☐</td>
</tr>
</tbody>
</table>

If No, please state reasons for non-immunisation (tick all that apply)  
Not offered ☐  Not available ☐  Contraindicated ☐  Safety concerns ☐  Woman’s preference ☐  Not known ☐

**Section 4: This Pregnancy**

4.1 Final Estimated Date of Delivery (EDD)  
D M Y YMD

4.2 Was this pregnancy a multiple pregnancy?  
Yes ☐  No ☐  
If Yes, specify number of fetuses

4.3Were there problems in this pregnancy?  
Yes ☐  No ☐  
If Yes, please specify ________________________________

4.4 Was the woman admitted to hospital?  
Yes ☐  No ☐  
If Yes, please give date of admission  
D M Y YMD

**Diagnosis of Influenza**

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

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Tick if Yes</th>
<th>If Yes, give date of onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>☐</td>
<td>D M Y YMD</td>
</tr>
<tr>
<td>Cough</td>
<td>☐</td>
<td>D M Y YMD</td>
</tr>
<tr>
<td>Sore throat</td>
<td>☐</td>
<td>D M Y YMD</td>
</tr>
<tr>
<td>Headache</td>
<td>☐</td>
<td>D M Y YMD</td>
</tr>
<tr>
<td>Tiredness/lethargy</td>
<td>☐</td>
<td>D M Y YMD</td>
</tr>
<tr>
<td>Limb or joint pain</td>
<td>☐</td>
<td>D M Y YMD</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>☐</td>
<td>D M Y YMD</td>
</tr>
<tr>
<td>Breathlessness</td>
<td>☐</td>
<td>D M Y YMD</td>
</tr>
<tr>
<td>Vomiting</td>
<td>☐</td>
<td>D M Y YMD</td>
</tr>
<tr>
<td>Rhinorrhea</td>
<td>☐</td>
<td>D M Y YMD</td>
</tr>
<tr>
<td>Flu-like symptoms</td>
<td>☐</td>
<td>D M Y YMD</td>
</tr>
</tbody>
</table>

*For guidance please see back cover*
4.6 Has virological testing for influenza been carried out?
   Yes ☐ No ☐

   If Yes, did this confirm the diagnosis?
   Yes ☐ No ☐

   If Yes, please specify

   Type identified (e.g. Influenza A H3N2) ________________________________
   Sample source ________________________________
   Date of first positive test DD/MM/YY
   Were there any subsequent positive tests?
   Yes ☐ No ☐
   If Yes, please give date(s) of subsequent positive tests
   1: DD/MM/YY
   2: DD/MM/YY

   If No, what was the final diagnosis? ________________________________

4.7 Was this a clinical diagnosis only?
   Yes ☐ No ☐

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

   If Yes, please specify

   Agent used ________________________________
   Date treatment started DD/MM/YY
   Date treatment stopped DD/MM/YY
   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

   Agent used ________________________________
   Date given DD/MM/YY
   Dose ________________________________

4.11 Was this woman managed with extracorporeal membrane oxygenation (ECMO)?
   Yes ☐ No ☐

   If Yes, please indicate:

   Date ECMO commenced DD/MM/YY
   Name of ECMO centre ________________________________
   Was this woman delivered during her ECMO treatment?
   Yes ☐ No ☐

   If Yes, please give reason for delivery ________________________________

*For guidance please see back cover
Section 5: Delivery

5.1 Did this woman have a miscarriage?  
Yes ☐  No ☐  
If Yes, please specify date  
D D / M M / Y Y

5.2 Did this woman have a termination of pregnancy?  
Yes ☐  No ☐  
If Yes, please specify date  
D D / M M / Y Y
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  
D D / M M / Y Y h m m

5.6 Was delivery by caesarean section?  
Yes ☐  No ☐
If Yes, please state:
Grade of urgency⁴  ☐
Indication for caesarean section ________________
Method of anaesthesia:  
Regional ☐  General anaesthetic ☐

*For guidance please see back cover
Section 6: Outcomes

Section 6a: Woman

6a.1 Was the woman admitted to Level 3 critical care?
   Yes ☐ No ☐
   If Yes, please specify
   Duration of stay ☐ days
   Or Tick if woman is still in Level 3 critical care ☐
   Or Tick if woman was transferred to another hospital ☐

6a.2 Did any other major maternal morbidity occur?* ☐
   Yes ☐ No ☐
   If Yes, please specify ____________________________

6a.3 What was the woman’s date of discharge after her admission for flu? D M Y Y M D

6a.4 Did the woman die?
   Yes ☐ No ☐
   If Yes, please specify date and time of death D M Y Y M D:
   h m h m 24 hr
   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 D M Y Y M D:

6b.2 Mode of delivery
   Spontaneous vaginal ☐ Ventouse or forceps ☐
   Breech ☐ Pre-labour caesarean section ☐ Caesarean section after onset of labour ☐

6b.3 Birthweight g

6b.4 Sex of infant:
   Male ☐ Female ☐ Indeterminate ☐

6b.5 Was the infant stillborn?
   Yes ☐ No ☐
   If Yes, please go to section 7.

6b.6 5 min Apgar

6b.7 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.8 Did any other major infant complications occur?* ☐
   Yes ☐ No ☐
   If Yes, please specify ____________________________

*For guidance please see back cover
6b.9 Did the infant have a congenital anomaly?  
Yes ☐  No ☐  
If Yes, please specify ________________________________

6b.10 Did this infant die?  
Yes ☐  No ☐  
If Yes, please specify date of death ____________________/
What was the primary cause of death as stated on the death certificate?  
(Please state if not known.) ________________________________

Section 7:
Please use this space to enter any other information you feel may be important
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Section 8:
Name of person completing the form ________________________________
Designation ________________________________
Today's date __________/_____/____/

You may find it useful in the case of queries to keep a copy of this form.

*For guidance please see back cover
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