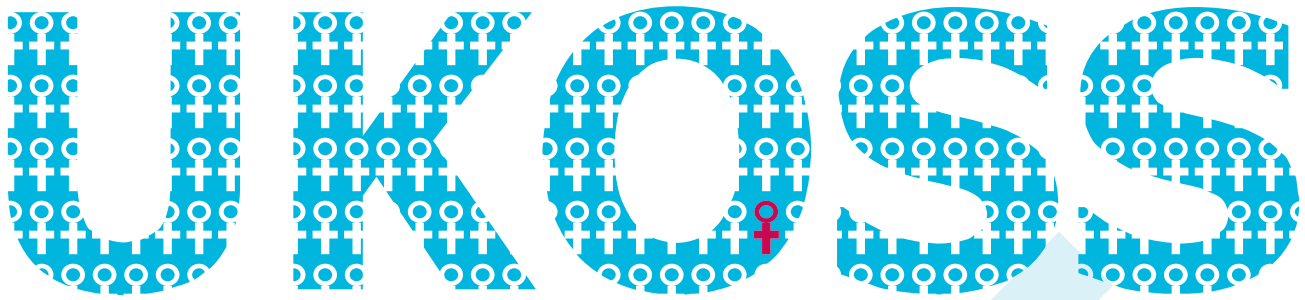


ID Number:



UK Obstetric Surveillance System

COVID-19 in Pregnancy Study 03/20

Data Collection Form - CASE

**Please report all pregnant women admitted on or after 1st March 2020
and before 1st March 2021**

Case Definition:

Any woman admitted to hospital with presumed or confirmed COVID-19 infection in pregnancy.



Royal College of
Obstetricians
and Gynaecologists

Bringing to life the best
in women's health care

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 617764 / 617774

Case reported in: _____



NPEU

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.

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
- 2.2 Did the woman have any previous pregnancy problems?^{2*}** Yes No
If Yes, please specify _____

*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?^{3*} Yes No

If Yes, please specify _____

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 / /

If Yes, what was her oxygen saturation on admission % or tick if not measured?

What was the primary reason for admission? (please tick one)

COVID-19 disease or symptoms Delivery Other

If Other, please specify _____

Diagnosis of COVID-19

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"/> |
| Anosmia | <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 COVID-19 been carried out?

Yes - for symptoms Yes - routine screening No

If Yes, did this confirm the diagnosis? Yes No

If Yes, please specify

Sample source _____

Date of first positive test / /

Were there any subsequent positive tests? Yes No

If Yes, please give date(s) of subsequent positive tests 1: / /

2: / /

If No, what was the final diagnosis? _____

4.7 Was this a clinical diagnosis only? Yes No

4.8 Did the women have confirmed pneumonia on imaging? Yes No

4.9 Was a potential source (contact) of COVID-19 infection identified? Yes No

If Yes, was the source in the UK Abroad

If Abroad, which country? _____

Therapy

4.10 Was this woman recruited to the RECOVERY trial? Yes No

4.11 Were anti-viral drugs used? 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 _____

4.12 Were other drugs used during pregnancy? Yes No

If Yes, please specify _____

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

If Yes, please specify

First Agent **Second Agent**

Agent used _____

Date given / /

Dose _____

4.14 Did the women require respiratory support for COVID-19 disease? Yes No

If Yes, what was the maximal level of support required (please tick one)

O₂ via nasal prongs O₂ via mask O₂ via non-rebreathe mask

CPAP Invasive ventilation ECMO

If this women received O₂ via nasal prongs or mask, what was the maximum flow rate

litres/min

If this women received ECMO, please indicate:

Date ECMO commenced

/ /

Name of ECMO centre _____

Was this woman delivered during her ECMO treatment?

Yes No

If Yes, please give reason for delivery _____

4.15 Were any of the following samples tested for SARS-COV-2 virus or antibody? (tick all that apply)

| Sample type | Tested? | If Yes, what was the test type e.g. PCR, IgG? | If Yes, what was the test result? |
|------------------------|--|---|-----------------------------------|
| Amniotic fluid | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ |
| Placenta | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ |
| Cord Blood | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ |
| High vaginal swab | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ |
| Faeces | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ |
| Other pregnancy tissue | Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ | _____ |

4.16 Did this women receive thromboprophylaxis or anticoagulation? Yes No

If Yes, please specify agent, dose and duration _____

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

5.7 Was delivery expedited due to COVID-19 disease?

Yes No

If Yes, what was the level of respiratory support she was receiving at the time of decision for delivery? (please tick one)

O₂ via nasal prongs

O₂ via mask

O₂ via non-rebreather mask

CPAP

Invasive ventilation

ECMO

If this women received O₂ via nasal prongs or mask, what was the maximum flow rate

litres/min

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?^{6*}

Yes No

If Yes, please specify _____

6a.3 What was the woman's date of discharge after her admission for COVID-19?

/ /

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 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 _____

6b.9 Was the infant diagnosed with COVID-19 infection?

Yes - sample taken <12 hours Yes – sample taken >=12 hours No

6b.10 Did the infant have a congenital anomaly? Yes No

If Yes, please specify _____

6b.11 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.

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