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 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:  

1.3 Marital status: single married cohabiting

1.4 Was the woman in paid employment at booking?  

   If Yes, what is her occupation: ____________________________

   If No, what is her partner’s (if any) occupation: ____________________________

1.5 Height and weight at booking: cm AND kg

1.6 Smoking status: never current gave up prior to pregnancy gave up during pregnancy

Section 2: Previous Obstetric History

2.1 Gravidity

   Number of completed pregnancies beyond 24 weeks: 

   Number of pregnancies less than 24 weeks: 

   If no previous pregnancies, please go to section 3

2.2 What was the date of delivery/termination/miscarriage in the most recent previous pregnancy: D M Y Y

2.3 Please indicate if any of the following were present in previous pregnancies:  

   (Please tick all that apply)

   Pregnancy induced hypertension (PIH) Pre-eclampsia Eclampsia

   HELLP syndrome Gestational diabetes

2.4 Did the woman have any other previous pregnancy problems?  

   Yes No

   If Yes, please specify: ____________________________

*For guidance please see back cover
Section 3: Previous Medical History

3.1 Did the woman have essential hypertension at booking or prior to pregnancy? [Yes [] No []]
   If Yes, was she receiving anti-hypertensive medication at booking or prior to pregnancy? [Yes [] No []]

3.2 Does the women have pre-existing diabetes mellitus? [Type 1 [] Type 2 [] Neither []]

3.3 Did the women have any other previous or pre-existing medical problems? [Yes [] No []]
   If Yes, please specify: ________________________________

Section 4:

Section 4a: This Pregnancy

4a.1 Final Estimated Date of Delivery (EDD): [YYYY-MM-DD]
4a.2 Was this a multiple pregnancy? [Yes [] No []]
   If Yes, please specify number of fetuses: __________________
4a.3 Date of booking: [YYYY-MM-DD]
4a.4 What was the platelet count at booking? [x10^9/L]
4a.5 Was the woman diagnosed with any of the following in this pregnancy? [Yes [] No []]
<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Date of diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy induced hypertension (PIH)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-eclampsia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eclampsia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestational diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4a.6 What were the levels of the following in this pregnancy or tick if not recorded:

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Tick if booking level not recorded</th>
<th>Level at booking</th>
<th>Tick if highest level not recorded</th>
<th>Highest Level</th>
<th>Date of highest level recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic BP (mmHg)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Diastolic BP (mmHg)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Proteinuria (please indicate units)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

4a.7 Were there any other problems in this pregnancy? [Yes [] No []]
   If Yes, please specify: ________________________________

*For guidance please see back cover
### Section 4b: Diagnosis and management of HELLP syndrome

#### 4b.1 Date and time of diagnosis of HELLP syndrome:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

#### 4b.2 Please indicate which of the following signs/symptoms were noted prior to or at diagnosis:

- Right upper abdominal quadrant or epigastric pain
- Nausea/vomiting
- Headache
- Visual changes
- Other

If Other please specify: ______________________

#### 4b.3 Please record the blood levels of the following at diagnosis and at their minimum level or tick if not recorded:

<table>
<thead>
<tr>
<th>Marker</th>
<th>Tick if diagnosis level not recorded</th>
<th>Level at diagnosis</th>
<th>Tick if lowest level not recorded</th>
<th>Lowest recorded level</th>
<th>Date lowest level recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platelet count (x10^9/L)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucose (mmol/L)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemoglobin (g/dL)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood gases - pH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 4b.4 Please record the blood levels of the following at diagnosis and at their maximum level or tick if not recorded:

<table>
<thead>
<tr>
<th>Marker</th>
<th>Tick if diagnosis level not recorded</th>
<th>Level at diagnosis</th>
<th>Tick if highest level not recorded</th>
<th>Highest recorded level</th>
<th>Date highest level recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>AST (iu/L)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALT (iu/L)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>γ-GT (iu/L)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDH (iu/L)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total bilirubin (µmol/l)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine (µmol/l)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White cell count (x10^9/L)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PT (sec)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APTT (sec)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood gases – base excess (mEq/L)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 4b.5 Was a peripheral blood smear performed?

- Yes [ ]
- No [ ]

If Yes, was there evidence of haemolysis (fragmented or contracted red cells)

- Yes [ ]
- No [ ]

#### 4b.6 Was diagnosis of HELLP syndrome:

- antepartum [ ]
- intrapartum [ ]
- postpartum [ ]

If antepartum, was the planned management immediately following diagnosis:

- Immediate delivery [ ]
- Delivery within 48 hours [ ]
- Expectant/conservative (prolonging pregnancy >48 hours) [ ]
4b.7 Was the woman given corticosteroids?
If Yes, please specify:

<table>
<thead>
<tr>
<th>Agent</th>
<th>Dose</th>
<th>Units</th>
<th>Indication</th>
<th>Date started</th>
</tr>
</thead>
</table>

4b.8 Was any antihypertensive medication commenced/continued in this pregnancy (antenatally or postnatally)?
If Yes, please specify:

<table>
<thead>
<tr>
<th>Name of drug</th>
<th>Date treatment started</th>
</tr>
</thead>
</table>

4b.9 Were any of the following treatments commenced/continued in this pregnancy (antenatally or postnatally)?

<table>
<thead>
<tr>
<th>Drug</th>
<th>Date treatment started</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magnesium sulphate</td>
<td></td>
</tr>
<tr>
<td>Aspirin</td>
<td></td>
</tr>
</tbody>
</table>

4b.10 Was any other medication commenced/continued in this pregnancy (antenatally or postnatally)?
If Yes, please specify:

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>Indication</th>
<th>Date treatment started</th>
</tr>
</thead>
</table>

4b.11 Did the women refuse blood products?
If No, were blood products given?

4b.12 Were any of the following used for thromboprophylaxis? (please tick all that apply)

<table>
<thead>
<tr>
<th></th>
<th>Antenatally</th>
<th>Postnatally</th>
</tr>
</thead>
<tbody>
<tr>
<td>TED Stockings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low molecular weight heparin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4b.13 Did the woman develop any overt clinical signs of coagulopathy (non-obstetric bleeding)? E.g. petechiae, haematuria, bleeding gums
If Yes, please specify: ________________

Section 5: Delivery

5.1 Did this woman have a miscarriage?
If Yes, please specify date:

5.2 Did this woman have a termination of pregnancy?
If Yes, please specify date:

*For guidance please see back cover
### Section 6: Outcomes

#### Section 6a: Woman

6a.1 **Was the woman admitted to ITU (critical care level 3) or obstetric HDU?**
- **Yes** [ ] **No** [ ]
  - If **Yes**, duration of stay: **days**
  - **OR** Tick if woman is still in ITU/HDU:
  - **OR** Tick if woman was transferred to another hospital:

6a.2 **Did the woman require ventilation?**
- **Yes** [ ] **No** [ ]

6a.3 **Did the woman require haemodialysis?**
- **Yes** [ ] **No** [ ]
  - If **Yes**, for how long was she dialysed: **days**

6a.4 **Did the woman have hepatic encephalopathy?**
- **Yes** [ ] **No** [ ]

6a.5 **Was the woman transferred to a liver unit?**
- **Yes** [ ] **No** [ ]

6a.6 **Did any other major maternal morbidity occur?**
- **Yes** [ ] **No** [ ]
  - If **Yes**, please specify:

6a.7 **Has the woman been discharged from hospital?**
- **Yes** [ ] **No** [ ]
  - If **Yes**, what was the date of the woman’s discharge from hospital? **/ /**
  - Was the woman readmitted after discharge?
    - **Yes** [ ] **No** [ ] **Not known** [ ]
  - If **Yes**, what was the reason for readmission?

6a.8 **Did the woman die?**
- **Yes** [ ] **No** [ ]
  - If **Yes**, please specify date and time of death **/ /**
  - What was the primary cause of death as stated on the death certificate? *(Please state if not known)*
  - **Yes** [ ] **No** [ ] **Not known** [ ]
  - **Was a post mortem examination undertaken?**
    - **Yes** [ ] **No** [ ] **Not known** [ ]
  - If **Yes**, did the examination confirm the diagnosis?
    - **Yes** [ ] **No** [ ] **Not known** [ ]

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*For guidance please see back cover*
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: ☐ ☐ ☐ ☐ Y Y D M h m

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 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 ☐

6b.8 Did any other major infant complications occur?*
- Yes ☐
- No ☐

If Yes, please specify: ____________________________

6b.9 Did this infant die?
- Yes ☐
- No ☐

If Yes, please specify date and time of death ☐ ☐ ☐ ☐ D M Y Y D M h m

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:

8.1 Name of person completing the form: ____________________________

8.2 Designation: _____________________________________________

8.3 Today’s date: ☐ ☐ ☐ ☐ Y Y M D

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, for example:**
   - 3 or more miscarriages
   - Acute fatty liver
   - Amniotic fluid embolism
   - Ante-partum haemorrhage requiring transfusion
   - Baby with major congenital problem
   - Hyperemesis requiring admission
   - IUGR/small for gestational age
   - Neonatal death
   - Placenta praevia
   - Placental abruption
   - Placenta accreta/percreta/increta
   - Post-partum haemorrhage requiring transfusion
   - Preterm birth or mid-trimester loss
   - Severe infection (e.g. pyelonephritis)
   - Stillbirth (IUD)
   - Surgical procedure in pregnancy
   - Significant antepartum haemorrhage
   - Thrombotic event (DVT/Pulmonary embolus/Stoke)

3. **Previous or pre-existing maternal medical problems, for example:**
   - Auto-immune disease
   - Cancer
   - Cardiac disease (congenital or acquired)
   - Epilepsy
   - Endocrine disorders, e.g. Hypo or hyperthyroidism
   - Haematological disorders e.g. sickle cell disease, diagnosed thrombophilia
   - Inflammatory disorders e.g. Inflammatory bowel disease
   - Psychiatric disorders
   - Renal disease
   - Thrombotic event (pulmonary embolism)
   - Coagulopathy
   - Polycystic ovary disease

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, for example:**
   - Adult respiratory distress syndrome
   - Cardiac arrest
   - Cerebrovascular accident/intercranial haemorrhage
   - Convulsions – not diagnosed as eclampsia
   - Disseminated intravascular coagulopathy (DIC)
   - Deranged clotting – not DIC
   - Multiple organ failure
   - Persistent vegetative state/anoxic/hypoxic brain injury
   - Pulmonary oedema
   - Septicaemia/septic shock
   - Thrombotic event

7. **Infant complications, for example:**
   - Chronic lung disease
   - Exchange transfusion
   - Intraventricular haemorrhage
   - Major congenital anomaly
   - Multiorgan failure
   - Necrotising enterocolitis
   - Neonatal encephalopathy/HIE/birth asphyxia
   - Respiratory distress syndrome/Ventilated/Pneumothorax/Chest effusions/Haemothorax
   - Severe infection e.g. septicaemia, meningitis
   - Severe jaundice requiring phototherapy