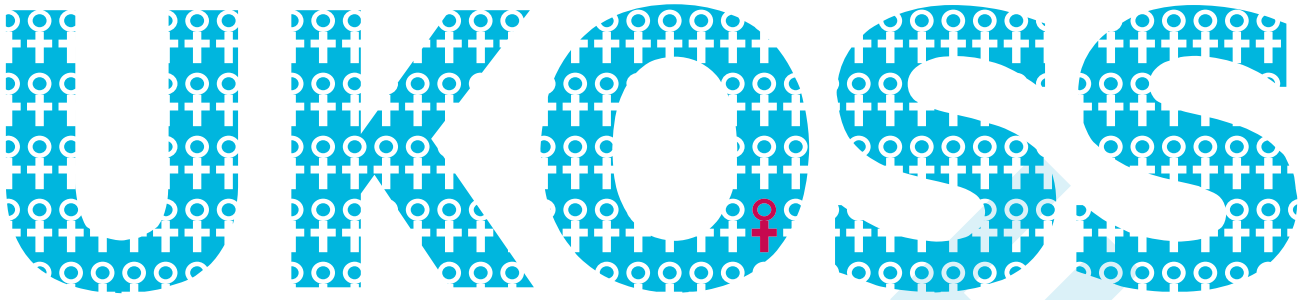


ID Number:



UK Obstetric Surveillance System

Pregnancy outcomes in mothers with a history of travel to a country with active Zika virus (ZIKV) transmission
Congenital Zika virus infection
Study 02/16

Data Collection Form - CASE

Please report any woman delivering between 1st Mar 2016 and 28th Feb 2017.

Case Definition:

A history of travel to an area with active Zika virus transmission during pregnancy or in the 4 weeks before conception where a fetal abnormality has been detected, or miscarriage, stillbirth, neonatal death or termination of pregnancy occurred.



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 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*}** (enter code, please see back cover for guidance)
- 1.3 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:

- 1.4 Height at booking:** cm
- 1.5 Weight at booking:** . kg
- 1.6 Smoking status:** never gave up prior to pregnancy
current gave up during pregnancy
- 1.7 Has this woman previously been reported to the UKOSS Zika Study?**
(i.e. with history of travel to a country with active Zika virus transmission during pregnancy but no adverse pregnancy outcome) Yes No

1.8 Did the mother travel to a country with active ZIKV transmission during pregnancy or within 4 weeks before conception? Yes No

If Yes, please indicate country/countries and subregion (if known) mother travelled to:

1. Country: _____ Subregion: _____

Date arrived: / / Date left: / /

2. Country: _____ Subregion: _____

Date arrived: / / Date left: / /

3. Country: _____ Subregion: _____

Date arrived: / / Date left: / /

If Yes, has the woman had any of the following symptoms/signs of illness since first arrival in the country with active ZIKV transmission? (Please tick all that apply)

Fever Rash Itching
Arthralgia/Arthritis Myalgia Conjunctivitis
Retro-orbital pain Other

If Other, please specify: _____

Date of first symptom onset: / /

Date last symptom resolved: / /

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 Did the woman have any of the following in previous pregnancies? (Please tick all that apply)

3 or more miscarriages

Preterm birth or mid trimester loss

Neonatal death

Stillbirth

Congenital abnormalities (E.g. autosomal recessive primary microcephaly (MCPH))

Please specify: _____

Other genetic disorders

Please specify: _____

Chromosomal disorders

Please specify: _____

2.3 Did the woman have any other previous pregnancy problems?^{2*} Yes No

If Yes, please specify: _____

*For guidance please see back cover

Section 3: Previous Medical History

3.1 Please indicate whether any of the following were present: (Please tick all that apply)

Phenylketonuria Hypothyroidism Known alcohol dependence
 Known substance misuse

If known substance misuse, please specify drugs/substances used:

3.2 Did the woman have any other pre-existing medical problem?^{3*} Yes No

If Yes, please give details: _____

3.3 Was the woman prescribed any regular medication in this pregnancy? Yes No

If Yes, please specify drug prescribed, date started and date stopped:

Drug	Date Started	Date Stopped
	DD / MM / YY	DD / MM / YY
	DD / MM / YY	DD / MM / YY

(continue in Section 7 if required)

Section 4: This Pregnancy

4.1 Final Estimated Date of Delivery (EDD):^{4*} DD / MM / YY

4.2 Was this a multiple pregnancy? Yes No

If Yes, please specify number of fetuses:

4.3 Did the woman have any of the following in this pregnancy? (Please tick all that apply)

Small for gestational age fetus Hypertension
 Gestational Diabetes Mellitus Abdominal injury Rhesus disease

4.4 Were abnormalities detected on antenatal ultrasound? Yes No

If Yes, was Microcephaly (>2SD below mean for gestational age) detected? Yes No

If Yes, please provide details:

Date detected: DD / MM / YY

Head Circumference: mm

Occipitofrontal diameter: mm

Femur length (FL): mm

Biparietal diameter: mm

Abdominal circumference: mm

Were any of the following detected?

Joint Contractures: Yes No If Yes, Date detected: DD / MM / YY

Craniofacial disproportion: Yes No If Yes, Date detected: DD / MM / YY

Intracranial calcifications: Yes No If Yes, Date detected: DD / MM / YY

Any other abnormalities: Yes No If Yes, Date detected: DD / MM / YY

If Yes, please specify other abnormalities: _____

*For guidance please see back cover

4.5 Was an antenatal fetal brain MRI done? Yes No

If Yes, were abnormalities detected on MRI? Yes No

If Yes, Were any of the following detected?

Cortical/subcortical atrophy: Yes No If Yes, Date detected: / /

Ventricular dilation: Yes No If Yes, Date detected: / /

Lissencephaly: Yes No If Yes, Date detected: / /

Pachygyria: Yes No If Yes, Date detected: / /

Any other abnormalities: Yes No If Yes, Date detected: / /

If Yes, please specify other abnormalities: _____

4.6 Were maternal samples collected for ZIKV testing? Yes No

If Yes, please indicate which samples and the date and result below:

EDTA blood: Yes No Date: / / Pos Neg

Urine: Yes No Date: / / Pos Neg

Amniotic fluid for Zika virus: Yes No Date: / / Pos Neg

Clotted blood for local save serum: Yes No Date: / /

4.7 Were any other screening tests performed? Yes No

If Yes, please indicate tests, date and result below:

Toxoplasmosis: Yes No Date: / / Pos Neg

Rubella: Yes No Date: / / Pos Neg

Cytomegalovirus: Yes No Date: / / Pos Neg

Herpes simplex: Yes No Date: / / Pos Neg

Syphilis: Yes No Date: / / Pos Neg

HIV: Yes No Date: / / Pos Neg

Karyotype/array CGH: Yes No Date: / / Result: _____

4.8 Were there any other problems in this pregnancy?^{2*} Yes No

If Yes, please specify: _____

Section 5: Delivery

5.1 Did this woman have a miscarriage? Yes No

If Yes, please specify date: / /

and cause (if known): _____

5.2 Did this woman have a termination of pregnancy (including hysterotomy)? Yes No

If Yes, please specify date: / /

and reason (if known): _____

If Yes to 5.1 or 5.2, please go to sections 6a, 7 and 8

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:

Will she be delivered at your hospital? Yes No

If No, please indicate name of delivery hospital, then *go to Section 7*

5.4 Was delivery induced? Yes No

If Yes, please state indication: _____

5.5 Did the woman labour? Yes No

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

Section 6: Outcomes

Section 6a: Woman

6a.1 Was the woman admitted to ITU or level 3 care? Yes No

If Yes, duration of stay: days

OR Tick if woman is still in ITU or level 3 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 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) _____

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: / / :

6b.2 Mode of delivery: Spontaneous vaginal Operative vaginal delivery 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, when did the fetus die? Antepartum **OR** Intrapartum

Cause of still birth (if known): _____

Please go to section 7

6b.6 5 min Apgar

6b.7 Was the infant admitted to the neonatal unit? Yes No

6b.8 Was Microcephaly (>2SD below mean for gestational age and sex) confirmed? Yes No

6b.9 Did the infant have any other confirmed anomalies? Yes No

If Yes, please specify: _____

6b.10 Did any other major infant complications occur?^{7*} Yes No

If Yes, please specify: _____

6b.11 Did this infant 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) _____

Was microcephaly confirmed at postmortem? Yes No

Were there any other abnormalities confirmed postmortem? Yes No

If Yes, please specify: _____

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: / /

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
Mendleson's syndrome
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