NORDIC GROUP

End of Pregnancy Form

☐Prospective ☐Retrospective

Date of declaration ___/___/____ (dd/mm/yyyy)

CONFIDENTIAL

Patient Initials: ___ ____ **Age** |__|__|
Forename / Surname

Date of first visit during pregnancy: ___/___/____ (dd/mm/yyyy)

1. MOTHER INFORMATION

1.1 Obstetrical history:

Gravidity |__|
Pathological pregnancy ☐No ☐Yes
Fœtal / neonatal abnormalities ☐No ☐Yes

1.2 Pregnancy ongoing:

Risks factors: ☐Diabetes ☐Cardiac pathology
☐Allergy ☐ Other……..

Pathology during pregnancy ☐ No ☐ Yes

Date of Last Mensual Period (LMP): ___/___/____ (dd/mm/yyyy)

Estimated date of delivery : ___/___/____ (dd/mm/yyyy)

1.3 Delivery:

☐Vaginal delivery
☐Caesarian, indication: ……..
☐Termination of pregnancy for medical reasons,
Date ___/___/____ (dd/mm/yyyy),
Term |__|__| Weeks post Last Mensual Period (W-LMP)

☐Termination of pregnancy,
Date ___/___/____ (dd/mm/yyyy),
Term |__|__| Weeks post Last Mensual Period (W-LMP)

1.4 Delivery complication? ☐No ☐Yes,
specify: ……

1.5 Drug received during pregnancy? ☐No ☐Yes
(If yes, complete the table below)

Product	Route	Posology	Start	Stop	Therapeutic Indications
1.					
2.					
3.					
4.					
5.					

2. PRENATAL TEST PERFORMED

2.1 A prenatal test performed: ☐No ☐Yes
(if no, go to the section 3)

Date of tests (✓) :

☐Ultrasound exam ___/___/___ (dd/mm/yyyy),Term|__|__|W-LMP

☐Ultrasound exam ___/___/___ (dd/mm/yyyy),Term|__|__| W-LMP

☐Ultrasound exam ___/___/___ (dd/mm/yyyy),Term|__|__| W-LMP

☐Amniocentesis ___/___/___ (dd/mm/yyyy),Term|__|__| W-LMP

☐Serology test ___/___/___ (dd/mm/yyyy),Term|__|__| W-LMP

☐Other ___/___/___ (dd/mm/yyyy),Term|__|__| W-LMP

☐Unknown *(go to the section 3)*

2.2 Structural malformation diagnosed with prenatal test performed:

☐No ☐Yes, specify _____
(If no, go to the section 3) _____
_____
_____

Test(s) which allowed detection of the malformation (✓) :

☐Ultrasound exam ___/___/____ (dd/mm/yyyy),Term|__|__| W-LMP

☐Amniocentesis ___/___/____ (dd/mm/yyyy),Term|__|__| W-LMP

☐Serology test ___/___/____ (dd/mm/yyyy),Term|__|__| W-LMP

☐Other ___/___/____ (dd/mm/yyyy),Term|__|__| W-LMP

☐Unknown *(go to the section 3)*

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3. NEONATAL AND ONE YEAR-OLD OUTCOME

3.1 Date of birth : ___/___/____ (dd/mm/yyyy)

3.2 Age at birth |__|__| post-LMP

3.3 Sex : ☐Female ☐Male

3.4 Weight at birth : _____ Kg

3.5 Height at birth : _____ cm

3.6 Head circumference at birth: _____ cm

3.7 Abnormalities detected at birth: ☐No ☐Yes *(If yes, specify)*
……
……

3.8 Neonatal pathology: ☐No ☐Yes (*If yes, specify)*
……
……

3.9 Maternal breast feeding: ☐No ☐Yes (*If yes, specify)*
……

3.10 Abnormalities detected one year after delivery: ☐No ☐Yes *(If yes, specify)*
……

Specify causal relationship with drug intake during pregnancy
☐ No ☐Yes (*If yes, specify which product*)
……

4. ADVERSE EVENT ☐No ☐Yes *(if yes, go to the section 4)*

4.1 Adverse event experienced by : ☐neonate ☐mother
4.2 Onset date: ___/___/____ (dd/mm/yyyy)
4.3 Duration: ……..
4.4 Seriousness (✓):
☐ Death, date: ___/___/____ (dd/mm/yyyy)
☐ Life threatening
☐ Congenital anomaly/Birth defect
☐ Involved/Prolonged patient hospitalisation
☐ Involved persistent or significant disability/incapacity
☐ Important medical event
4.5 Outcome (✓):
☐ Recovered
☐ Recovered with sequelae
☐ Death due to the adverse event
☐ Death might be due to the adverse event
☐ Death not due to the adverse event
☐ Not recovered
☐ Unknown
4.6 Description of the adverse event (please, attach additional test of the mother/child):
……
……
……
……

5. PATERNAL DRUG EXPOSURE DURING THE MONTH BEFORE CONCEPTION

Product	Route	Posology	Start	Stop	Therapeutic Indications
1.					
2.					
3.					
4.					

6. OTHER COMMENTS

7. REPORTER

1. Name: _____ 2. Specialty : _____

3. Adress: _____

4. Phone number: _____ 5. Fax : _____

6. Date : ___/___/____ (dd/mm/yyyy) 7. Signature :

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