ID: CCP-______- ______

Canadian COVID-19 in Pregnancy Surveillance: Epidemiology, Maternal and Infant Outcomes

SOURCE OF REPORTING	
Site completing DCF:	
Name of individual(s) completing forms:	Email for follow-up reminder:
Date case report forms completed (dd.mmm.yyyy): ___________________________	

MATERNAL DEMOGRAPHICS

1. Has the patient signed an informed consent? ▢ no– research ethics waiver of consent ▢ yes, Date:______
2. Maternal age at estimated date of delivery (EDD): _______________ ▢ unknown
3. Ethnicity - maternal:

please select all that apply ↗ → ↘

- ▢ White / Caucasian
- ▢ African / Caribbean / Black
- ▢ Hispanic / Latino
- ▢ East Asian
- ▢ South Asian
- ▢ South East Asian
- ▢ West Central Asian / Middle Eastern
- ▢ Indigenous / Aboriginal / First Nations / Métis / Inuit
- ▢ Other (specify ethnicities of parents) ________________________________
- ▢ Unknown ________________________________

4. Maternal country of birth ________________________________ ▢ unknown
5. Employment status during pregnancy:
   ▢ Employed
   ▢ Unemployed
   ▢ Unknown
6. Current occupation: ___________________ ▢ unknown
7. Kind of business, industry or service?: ___________________ ▢ unknown
8. No. of school years completed - maternal: _______________________ ▢ unknown
9. Partner: ▢ no ▢ yes ▢ unknown - Living With partner? ▢ no ▢ yes ▢ unknown
10. Country of residence, if other than Canada: _______________ ▢ unknown
11. Province of residence: ___________ ▢ unknown
12. First 3 digits of postal code:____________ ▢ unknown

SARS-COV-2 HISTORY, MATERNAL TESTING, SYMPTOMS, TREATMENTS, & HOSPITALIZATONS THROUGH FOLLOW-UP FORMS

SARS-COV-2 EXPOSURE HISTORY

NOTE: Record all testing information on Maternal and Infant SARS-COV 2 Testing DCFs:
Maternal testing on page 3, Infant testing on page 14 of the INTRAPARTUM DATA COLLECTION FORMS

1. **Exposure information**	**Dates, if known** (dd.mmm.yyyy)
I. ▢ Travel, if yes, countr(ies): ________________________________ II. ▢ Known contact in community III. ▢ Occupational risk, specify: IV. ▢ Unknown V. ▢ Other, describe: ______________________________________	
2. **Comments:**	

MATERNAL SARS-COV-2 TESTING

NOTE: Please include all maternal SARS-COV-2 testing results, record infant testing on page 14 of the INTRAPARTUM DATA COLLECTION FORMS

1. Specimen	Collection Date / Time (dd.mmm.yyyy/hh.mm)	Lab Report Date (dd.mmm.yyyy)	Test	Result
□ Nasopharyngeal swab #1	Date: Time:			□ Pos □ Neg □ Indeterminate □ Pending □ Unknown
□ Nasopharyngeal swab #2	Date: Time:			□ Pos □ Neg □ Indeterminate □ Pending □ Unknown
□ Throat swab	Date: Time:			□ Pos □ Neg □ Indeterminate □ Pending □ Unknown
□ Blood	Date: Time:			□ Pos □ Neg □ Indeterminate □ Pending □ Unknown
□ Breast Milk	Date: Time:			□ Pos □ Neg □ Indeterminate □ Pending □ Unknown
□ Amniotic fluid	Date: Time:			□ Pos □ Neg □ Indeterminate □ Pending □ Unknown
□ Serology – IgM	Date: Time:			□ Pos □ Neg □ Indeterminate □ Pending □ Unknown
□ Serology – IgG	Date: Time:			□ Pos □ Neg □ Indeterminate □ Pending □ Unknown
□ Other SARS-COV-2 testing if clinically indicated: __________________	Date: Time:			□ Pos □ Neg □ Indeterminate □ Pending □ Unknown

□ Other SARS-COV-2 testing if clinically indicated: _________________	Date: Time:			□ Pos □ Neg □ Indeterminate □ Pending □ Unknown

Other tests performed?

2. Influenza: ▢ no ▢ yes ▢ unknown, **If yes**: Date:______ ▢ positive ▢ negative ▢ unknown
   IF positive: ▢ positive for influenza A ▢ positive for influenza B

3. Respiratory-Syncytial Virus: ▢ no ▢ yes ▢ unknown, **If yes**: Date:______ ▢ pos ▢ neg ▢ unknown

MATERNAL CLINICAL PRESENTATION

NOTE: Please record all symptoms imaging, complications, treatments and medications during follow-up. Record information available and update as necessary.

NOTE: Record all medications and supplements taken for COVID on COVID medications form (p.9-11) and other medications on General Medications & Supplements form. Add all SARS-Cov-2 testing to testing DCF on page 3 for maternal testing and for infant testing on page 14 of the INTRAPARTUM DATA COLLECTION FORMS

1. Date of COVID diagnosis, if known (dd.mmm.yyyy): _______________

2. Estimated date of acquisition, if known (dd.mmm.yyyy): _______________

3. Illness onset date, if known (dd.mmm.yyyy): _______________

4. Asymptomatic at presentation? ☐ no (if no, proceed to symptoms table below)

☐ yes (if yes, patient asymptomatic, skip symptoms table)

5. **Symptoms during COVID illness episode:**		
I. Fever ☐ no ☐ yes ☐ unk ☐ < 38°C ☐ 38-39°C ☐ >39°C ☐ Unk	II. Cough ☐ no ☐ yes ☐ unk	III. Headache ☐ no ☐ yes ☐ unk
IV. Shortness of breath ☐ no ☐ yes ☐ unk	V. Runny nose ☐ no ☐ yes ☐ unk	VI. Muscle pain/myalgia ☐ no ☐ yes ☐ unk
VII. Anorexia (loss of appetite ☐ no ☐ yes ☐ unk	VIII. Diarrhea ☐ no ☐ yes ☐ unk	IX. Vomiting ☐ no ☐ yes ☐ unk
X. Malaise ☐ no ☐ yes ☐ unk	XI. Fatigue ☐ no ☐ yes ☐ unk	XII. Anosmia or ageusia (loss of smell or taste): ☐ no ☐ yes ☐ unk
XIII. Sore throat ☐ no ☐ yes ☐ unk	XIV. Sputum production ☐ no ☐ yes ☐ unk	XV. Nausea ☐ no ☐ yes ☐ unk
XVI. Non-specific respiratory symptoms ☐ no ☐ yes ☐ unk	XVII. Other Sx:_______________ ☐ no ☐ yes ☐ unk	XVIII. Other Sx: ______________ ☐ no ☐ yes ☐ unk

6. **COMPLICATIONS (at any time, in pregnancy or postpartum)**

	Complication	Response	Date	Duration
I.	Pneumonia	☐ no ☐ yes ☐ unk	Date:_________	Duration? _________
II.	Sepsis	☐ no ☐ yes ☐ unk	Date:_________	Duration? _________
III.	Respiratory Failure	☐ no ☐ yes ☐ unk	Date:_________	Duration? _________
IV.	Acute Respiratory Distress Syndrome	☐ no ☐ yes ☐ unk	Date:_________	Duration? _________
V.	Heart Failure	☐ no ☐ yes ☐ unk	Date:_________	Duration? _________
VI.	Septic Shock	☐ no ☐ yes ☐ unk	Date:_________	Duration? _________
VII.	Coagulopathy	☐ no ☐ yes ☐ unk	Date:_________	Duration? _________
VIII.	Renal Failure	☐ no ☐ yes ☐ unk	Date:_________	Duration? _________
IX.	Liver dysfunction	☐ no ☐ yes ☐ unk	Date:_________	Duration? _________
X.	Disseminated intravascular coagulopathy	☐ no ☐ yes ☐ unk	Date:_________	Duration? _________
XI.	Hospital Admission *For those hospitalized, complete hospitalization form	☐ no ☐ yes ☐ unk	Date:_________	Duration? _________
XII.	Maternal Death	☐ no ☐ yes ☐ unk	*If yes complete maternal death form	
XIII.	Other, Specify:	☐ no ☐ yes ☐ unk	Date:_________	Duration? _________

7. **CHEST IMAGING:**

I. X-ray test performed?
☐ no ☐ yes Date: ______________ ☐ unknown
☐ abnormal ☐ normal ☐ pending ☐ unk
If abnormal, result: ____

II. Second X-ray performed?
☐ no ☐ yes Date: ______________ ☐ unknown
☐ abnormal ☐ normal ☐ pending ☐ unk
If abnormal, result: ____

III. CT scan test performed?
▢ no ▢ yes Date: ______________ ▢ unknown
▢ abnormal ▢ normal ▢ pending ▢ unk
If abnormal, result: ____

IV. Second CT performed?
▢ no ▢ yes Date: ______________ ▢ unknown
▢ abnormal ▢ normal ▢ pending ▢ unk
If abnormal, result: ____

V. MRI test performed?
▢ no ▢ yes Date: ______________ ▢ unknown
▢ abnormal ▢ normal ▢ pending ▢ unk
If abnormal, result: ____

VI. Second MRI performed?
▢ no ▢ yes Date: ______________ ▢ unknown
▢ abnormal ▢ normal ▢ pending ▢ unk
If abnormal, result: ____

VII. Other chest imaging, Specify: _________________
▢ no ▢ yes Date: ______________ ▢ unknown
▢ abnormal ▢ normal ▢ pending ▢ unk
If abnormal, result: ____

8. **OTHER IMAGING (non-chest):**

a. ▢ no ▢ yes ▢ unk Imaging type: _____________________ Date: _____________
▢ abnormal ▢ normal ▢ pending ▢ unk
If abnormal, result: ____

b. ▢ no ▢ yes ▢ unk Imaging type: _____________________ Date: _____________
▢ abnormal ▢ normal ▢ pending ▢ unk
If abnormal, result: ____

c. ▢ no ▢ yes ▢ unk Imaging type: _____________________ Date: _____________
▢ abnormal ▢ normal ▢ pending ▢ unk
If abnormal, result: ____

9. **TREATMENT**

Were any of the following treatments performed? ▢ **yes** ▢ **no** ▢ **unk**

I.	▢ Intravenous immunoglobulin	Date _________	Duration ________	Dose _______
II.	▢ Oxygen (outside of at delivery)?	Date _________	Duration (days, CUMULATIVE):______ Maximal therapy delivered, L per minute:________________	
III.	▢ High-flow nasal cannula oxygen therapy	Date _________	Duration ________	
IV.	▢ Invasive mechanical ventilation	Date _________	Duration ________	
V.	▢ Non-invasive mechanical ventilation	Date _________	Duration ________	
VI.	▢ ECMO	Date _________	Duration ________	
VII.	▢ Renal replacement therapy	Date _________	Duration ________	
VIII.	▢ Vasopressors	Date _________	Duration ________	
IX.	▢ Other, specify ______________________	Date _________	Duration ________	
X.	▢ Other, specify ______________________	Date _________	Duration ________	
XI.	▢ Other, specify ______________________	Date _________	Duration ________	

ID: CCP-______- ______

COVID-19 MEDICATIONS AND NATURAL HEALTH PRODUCTS

NOTE: Please record medications, OTC and prescription, and natural health products, taken in pregnancy and birth for COVID-19 here. Record postpartum COVID medications on postpartum forms. Record medications for other indications on General Medications form.

OVER THE COUNTER MEDICATIONS: ☐ No over the counter medications ☐ Unknown

1. ☐ OTC meds (check all taken)
   - ☐ Acetaminophen (Tylenol)
   - ☐ NSAIDS
     - ☐ Acetylsalicylic acid (Aspirin)
     - ☐ Ibuprofen (Advil, Motrin, others)
     - ☐ Naproxen (Aleve, Naprosyn, others)
     - ☐ Other ____________________
     - ☐ Other____________________
   - ☐ Other: _________________________

PRESCRIPTION MEDICATIONS: ☐ No prescription medications ☐ Unknown

2. ☐ Corticosteroids (check all taken)			
☐ Dexamethasone	☐ Clinical trial?	Dose:	Duration:
☐ Other, specify _________________	☐ Clinical trial?	Dose:	Duration:
☐ Other, specify _________________	☐ Clinical trial?	Dose:	Duration:
3. ☐ Steroids for fetal lung maturation, specify:	☐ Clinical trial?	Dose:	Duration:
4. ☐ Chloroquine. If yes, describe circumstance:	☐ Clinical trial?	Dose:	Duration:
5. ☐ Hydroxychloroquine. If yes, describe circumstance:	☐ Clinical trial?	Dose:	Duration:

6. ☐ Colchicine	☐ Clinical trial?	Dose:	Duration:
7. ☐ Antiviral (check all taken)			
☐ Kaletra (Lopinavir/Ritonavir)	☐ Clinical trial?	Dose:	Duration:
☐ Remdesivir	☐ Clinical trial?	Dose:	Duration:
☐ Other, specify ______________________	☐ Clinical trial?	Dose:	Duration:
☐ Other, specify ______________________	☐ Clinical trial?	Dose:	Duration:
8. ☐ Antibiotics (check all taken)			
☐ Specify ______________________	☐ Clinical trial?	Dose:	Duration:
☐ Specify ______________________	☐ Clinical trial?	Dose:	Duration:
9. ☐ Other __________________________	☐ Clinical trial?	Dose:	Duration:
10. ☐ Other __________________________	☐ Clinical trial?	Dose:	Duration:
11. ☐ Other __________________________	☐ Clinical trial?	Dose:	Duration:
12. ☐ Other __________________________	☐ Clinical trial?	Dose:	Duration:

NATURAL HEALTH PRODUCTS FOR COVID: ▢ No natural health products ▢ Unknown	
13. ▢ Natural health products	▢ Specify ___________________________ ▢ Specify ___________________________ ▢ Specify ___________________________ ▢ Specify ___________________________

HOSPITALIZATION FORM

1. **Symptoms at admission (outside of admission for delivery):**		
I. Fever ☐ no ☐ yes ☐ unk ☐ < 38°C ☐ 38-39°C ☐ >39°C ☐ Unk	II. Cough ☐ no ☐ yes ☐ unk	III. Headache ☐ no ☐ yes ☐ unk
IV. Shortness of breath ☐ no ☐ yes ☐ unk	V. Runny nose ☐ no ☐ yes ☐ unk	VI. Muscle pain/myalgia ☐ no ☐ yes ☐ unk
VII. Anorexia (loss of appetite) ☐ no ☐ yes ☐ unk	VIII. Diarrhea ☐ no ☐ yes ☐ unk	IX. Vomiting ☐ no ☐ yes ☐ unk
X. Malaise ☐ no ☐ yes ☐ unk	XI. Fatigue ☐ no ☐ yes ☐ unk	XII. Anosmia or ageusia (loss of smell or taste): ☐ no ☐ yes ☐ unk
XIII. Sore throat ☐ no ☐ yes ☐ unk	XIV. Sputum production ☐ no ☐ yes ☐ unk	XV. Nausea ☐ no ☐ yes ☐ unk
XVI. Non-specific respiratory symptoms ☐ no ☐ yes ☐ unk	XVII. Other Sx:_______________ ☐ no ☐ yes ☐ unk	XVIII. Other Sx: ______________ ☐ no ☐ yes ☐ unk

2. **Admitted to ICU?** ☐ yes ☐ no ☐ unknown

3. **Highest patient temperature?** ☐ <38°C ☐ 38-39°C ☐ > 39°C ☐ unknown

4. **Maternal heart rate at admission (bpm)**

   ☐ <100 bpm (NORMAL) ☐ 100-110 bpm ☐ 111-120 bpm ☐ >120 bpm ☐ unk

5. **Maternal systolic blood pressure ad admission (mmHg): ______**

6. **Maternal diastolic blood pressure at admission (mmHg): ______**

7. **Respiratory rate of admission (/min):**

   ☐ <22/min ☐ 22-34/min ☐ > 34/min ☐ unknown

8. **Peripheral oxygen saturation at admission (Sp02%): _______**

9. Altered mental status: ▢ yes ▢ no ▢ unknown

10. ECG at admission: ▢ yes ▢ no ▢ unknown

If yes, ECG result: ▢ normal ▢ abnormal ▢ unknown

11. Abnormal lab result if tested, for the following while inpatient:

I. Platelet count	Within normal range? Yes ▢ No ▢ If no, value______ Date:______ ▢ unk ▢ no test
II. White blood count (WBC)	Within normal range? Yes ▢ No ▢ If no, value______ Date:______ ▢ unk ▢ no test
III. Haemoglobin	Lowest value: __________ Date:____________ ▢ unk ▢ no test
IV. CRP	Highest value: __________ Date:____________ ▢ unk ▢ no test
V. Lactate dehydrogenase (U/L >245)	▢ yes- High? ▢ Low? ▢ Worst value: _________ Date:_________ ▢ unk ▢ no test
VI. ALT (U/L >40)	▢ yes- High? ▢ Low? ▢ Worst value: _________ Date:_________ ▢ unk ▢ no test
VII. Creatinine	Highest value___________ Date:____________ ▢ unk ▢ no test
VIII. Uric acid	Highest value___________ Date:____________ ▢ unk ▢ no test

ANTEPARTUM DATA COLLECTION FORMS

ID: CCP-______- ______

PREGNANCY HISTORY

Please provide information on all prior pregnancies.

NOTE: : T/a = Therapeutic abortion ; S/a= Spontaneous abortion

1.

I. **# G**ravida ____ ☐ Unknown

II. **# T**erm ____ ☐ Unknown

III. **# P**reterm ____ ☐ Unknown

IV. **# A**bortion ____ (Induced ____ ☐ Unknown Spontaneous ____ ☐ Unknown)

V. **# L**iving ____ ☐ Unknown

					Children		
	Year of birth/ event	**Gest. Age (wks & days)**	**Type of birth**	**Perinatal complications**	**Sex**	**Birth weight**	**Present health (alive and well/ demised/ significant health issue)**
2.		☐ Unk ☐ N/a	☐ Vag ☐ C/s ☐ T/a ☐ S/a ☐ Unk ☐ N/a	☐ Preeclampsia ☐ Intrauterine Growth Restriction ☐ Fetal Malformation ☐ Preterm birth ☐ Postpartum hemorrhage ☐ Other, specify: ☐ N/a		☐ Unk ☐ N/a	☐ Alive/ well ☐ Demised ☐ Significant health issue: ☐ Unk ☐ N/a
3.		☐ Unk ☐ N/a	☐ Vag ☐ C/s ☐ T/a ☐ S/a ☐ Unk ☐ N/a	☐ Preeclampsia ☐ Intrauterine Growth Restriction ☐ Fetal Malformation ☐ Preterm birth ☐ Postpartum hemorrhage ☐ Other, specify: ☐ N/a		☐ Unk ☐ N/a	☐ Alive/ well ☐ Demised ☐ Significant health issue: ☐ Unk ☐ N/a
4.		☐ Unk ☐ N/a	☐ Vag ☐ C/s ☐ T/a ☐ S/a ☐ Unk ☐ N/a	☐ Preeclampsia ☐ Intrauterine Growth Restriction ☐ Fetal Malformation ☐ Preterm birth ☐ Postpartum hemorrhage ☐ Other, specify: ☐ N/a		☐ Unk ☐ N/a	☐ Alive/ well ☐ Demised ☐ Significant health issue: ☐ Unk ☐ N/a
5.		☐ Unk ☐ N/a	☐ Vag ☐ C/s ☐ T/a ☐ S/a ☐ Unk ☐ N/a	☐ Preeclampsia ☐ Intrauterine Growth Restriction ☐ Fetal Malformation ☐ Preterm birth ☐ Postpartum hemorrhage ☐ Other, specify: ☐ N/a		☐ Unk ☐ N/a	☐ Alive/ well ☐ Demised ☐ Significant health issue: ☐ Unk ☐ N/a
6.		☐ Unk ☐ N/a	☐ Vag ☐ C/s ☐ T/a ☐ S/a ☐ Unk ☐ N/a	☐ Preeclampsia ☐ Intrauterine Growth Restriction ☐ Fetal Malformation ☐ Preterm birth ☐ Postpartum hemorrhage ☐ Other, specify: ☐ N/a		☐ Unk ☐ N/a	☐ Alive/ well ☐ Demised ☐ Significant health issue: ☐ Unk ☐ N/a

PREGNANCY INFORMATION

1. Calculated LMP (dd/mmm/yyyy):
   ☐ Unknown ________________________________

2. Confirmed estimated date of delivery (dd/mmm/yyyy): ________________________________
   I. Based on (best available method):
   - ☐ Last menstrual period
   - ☐ First trimester ultrasound with an embryo ≥ 10mm
   - ☐ Ultrasound (if second trimester +)
   - ☐ Unknown

3. IVF pregnancy? ☐ No
   ☐ Yes -> Specify ____________________________________
   ☐ Unknown

4. Alcohol use in pregnancy: ☐ No ☐ Yes ☐ Unknown
   I. Binge drinking in pregnancy: ☐ No ☐ Yes ☐ Unknown

5. Substance use in pregnancy (outside of medications prescribed to patient): ☐ No ☐ Yes ☐ Unknown
   I. If yes, ☐ Heroin ☐ Cocaine ☐ Marijuana ☐ Solvents ☐ Other_________________ ☐ Unknown

6. Smoking before pregnancy: ☐ Never ☐ Quit (DD/MMM/YYYY)__________________ ☐ Unknown
   I. If yes, average # cigarettes ______ /day OR ______ / week ☐ Unknown

7. Smoking during pregnancy: ☐ No ☐ Yes ☐ Unknown
   I. If yes, average # cigarettes ______ /day OR ______ / week ☐ Unknown

8. Exposure 2nd hand smoke during pregnancy: ☐ No ☐ Yes ☐ Unknown

9. Height (cm): ☐ Unknown	10. Weight pre / early pregnancy (kg; weight right before pregnancy or earliest recorded in pregnancy): ☐ Unknown

11. # Fetuses: ☐ 1 ☐ 2 ☐ 3 ☐ ≥ 4, specify # : _____________ ☐ Unknown
    I. If multiples:
    - ☐ Twin: Dichorionic Diamniotic
    - ☐ Twin: Monochorionic Diamniotic
    - ☐ Twin: Monochorionic Monoamniotic
    - ☐ Triplets: specify_______________
    - ☐ Other, specify _________
    - ☐ Unknown

COMORBIDITIES IN PREGNANCY

Please report maternal health comorbidities in pregnancy

1. ⇨ ☐ **no comorbidities, skip to pregnancy screening**

NOTE: Record all medications on COVID medications / General medications forms

Check all that apply

BODY SYSTEM	DIAGNOSIS	MEDICATIONS
i. CNS - Central Nervous System ☐ Yes ☐ No ☐ Unk	☐ Chronic headaches	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Migraines	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Epilepsy	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Other ___________________	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
ii. EENT+M - Ears, Eyes, Nose Throat & Mouth ☐ Yes ☐ No ☐ Unk *Allergies go in xiii. Allergies/ immune	☐ Specify: __________________	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Specify: __________________	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
iii. CVS – Cardiovascular If gest hypertension, document under complications related to pregnancy page 10 ☐ Yes ☐ No ☐ Unk	☐ Hypertension	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Arrhythmia: ______________	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Valve conditions	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Other ___________________	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form

BODY SYSTEM	DIAGNOSIS	MEDICATIONS
iv. RESP - Respiratory ▢ Yes ▢ No ▢ Unk	▢ Asthma	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
	▢ Chronic obstructive lung disease	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
	▢ Other ___________________	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
v. GI - Gastrointestinal ▢ Yes ▢ No ▢ Unk	▢ Irritable bowel disease (IBD)	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
	▢ Celiac	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
	▢ Other	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
vi. GU – Genitourinary ▢ Yes ▢ No ▢ Unk	▢ Recurrent urinary tract infection (UTI)	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
	▢ Other ___________________	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
	▢ Other ___________________	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
vii. REPRO – Reproductive ▢ Yes ▢ No ▢ Unk	▢ Short cervix history	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
	▢ Short cervix current preg	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
	▢ Other ___________________	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form

BODY SYSTEM	DIAGNOSIS	MEDICATIONS
viii. ENDO – Endocrine If gest diabetes, document under complications related to pregnancy, page 10 ☐ Yes ☐ No ☐ Unk	☐ Thyroid function imbalances ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Other ___________________	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Diabetes type 1	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Diabetes type 2	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Other ___________________	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
ix. MS - Musculoskeletal ☐ Yes ☐ No ☐ Unk	☐ Rheumatoid arthritis	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Ankylosing spondylitis	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Lupus ___________________	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Other ___________________	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form

BODY SYSTEM	DIAGNOSIS	MEDICATIONS
x. HEM - Hematologic ☐ Yes ☐ No ☐ Unk	☐ Thrombocytopenia	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Deep vein thrombosis (DVT)	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Immune thrombocytopenic purpura (ITP)	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Anemia	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Other ___________________	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
xi. MH - Mental Health ☐ Yes ☐ No ☐ Unk	☐ Depression	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Anxiety	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Schizophrenia	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Bipolar	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form
	☐ Other ___________________	Taking medication? ☐ no ☐ yes ☐ Unk * If yes, indicate in General Meds Form

BODY SYSTEM	DIAGNOSIS	MEDICATIONS
xii. AAI - Allergies / Autoimmune Disorders ▢ Yes ▢ No ▢ Unk	▢ Allergies, Drug, specify:	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
	▢ Allergies, environmental/ food specify:	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
	▢ Other ___________________	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
xiii. Other 1 ______________________ ↑ body system ↑ ▢ Yes ▢ No ▢ Unk	▢ Other ___________________	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form
xiii. Other 2 ______________________ ↑ body system ↑ ▢ Yes ▢ No ▢ Unk	▢ Other ___________________	Taking medication? ▢ no ▢ yes ▢ Unk * If yes, indicate in General Meds Form

PREGNANCY SCREENING

1. Aneuploidy screening

Screening test if available	unknown	not done	date, if done (dd/mmm/yyyy)	Result	Comments
i. NIPT	☐	☐		☐ neg/norm ☐ pos ☐ unk	
ii. Serum Screening	☐	☐		☐ neg/norm ☐ pos ☐ unk	
iii. Amniocentesis	☐	☐		☐ neg/norm ☐ pos ☐ unk	
iv. Other: _______________	☐	☐		☐ neg/norm ☐ pos ☐ unk	

2. Infectious serotesting

i. HIV ☐ neg/ unreactive ☐ pos/ reactive ☐ unk ☐ not tested

ii. HBV sAg ☐ neg/ unreactive ☐ pos/ reactive ☐ unk ☐ not tested

iii. HCV ☐ neg/ unreactive ☐ pos/ reactive ☐ unk ☐ not tested

iv. GBS ☐ neg/ unreactive ☐ pos/ reactive ☐ unk ☐ not tested

v. Syphilis ☐ neg/ unreactive ☐ pos/ reactive ☐ unk ☐ not tested

vi. Gonorrhea ☐ neg/ unreactive ☐ pos/ reactive ☐ unk ☐ not tested

vii. Chlamydia ☐ neg/ unreactive ☐ pos/ reactive ☐ unk ☐ not tested

viii. Rubella ☐ neg/ unreactive ☐ pos/ reactive ☐ unk ☐ not tested

viii. Varicella Zoster Virus ☐ neg/ unreactive ☐ pos/ reactive ☐ unk ☐ not tested

ix. Other: ______________ ☐ neg/ unreactive ☐ pos/ reactive ☐ unk ☐ not tested

x. Other: ______________ ☐ neg/ unreactive ☐ pos/ reactive ☐ unk ☐ not tested

xi. Other: ______________ ☐ neg/ unreactive ☐ pos/ reactive ☐ unk ☐ not tested

xii. Other: ______________ ☐ neg/ unreactive ☐ pos/ reactive ☐ unk ☐ not tested

xiii: Comments:

ID: CCP-______- ______

COMPLICATIONS RELATED TO PREGNANCY

During this pregnancy, did any of the following occur?

NOTE 1: In the event of a pregnancy loss, document on Pregnancy Loss form
NOTE 2: This form should include all pregnancy – complete with available information & update through to end preg
NOTE 3: Record all medications for COVID indication in COVID medications table on page 9-11 in SARS-COV-2 HISTORY, MATERNAL TESTING, SYMPTOMS, TREATMENTS, & HOSPITALIZATONS THROUGH FOLLOW-UP forms
NOTE 4: Records all other medications in General Medications form

Data abstraction complete through delivery? ☐ no ☐ yes ☐ Unk

Event	Occurred?	Date(s) (if unk: month, GA or trimester)	Comments
1. Bleeding	☐ no ☐ yes ☐ Unk		I. Etiology? ☐ Placental abruption ☐ Placenta previa ☐ Cervix ☐ Other, specify: ☐ Unk
2. Progesterone given to prevent premature birth	☐ no ☐ yes ☐ Unk		
3. Cerclage	☐ no ☐ yes ☐ Unk	Surgery date:	
4. Preterm premature rupture of membranes	☐ no ☐ yes ☐ Unk		
5. Preterm labour	☐ no ☐ yes ☐ Unk		
6. Cholestasis of pregnancy	☐ no ☐ yes ☐ Unk		
7. Hypertensive disorder of pregnancy	☐ no ☐ yes ☐ Unk		
8. Gestational diabetes	☐ no ☐ yes ☐ Unk		☐ Diet controlled ☐ Insulin controlled ☐ Metformin ☐ Unknown
9. Pregnancy Loss	☐ no ☐ yes ☐ Unk		**DOCUMENT ON PREGNANCY LOSS FORM**
10. Other ________________	☐ no ☐ yes ☐ Unk		

ULTRASOUND RESULTS – Complete separate form for each ultrasound **(Ultrasound #____of ____)**

1. Date (dd.mmm.yyyy): ____________________	**Dating ultrasound**: ☐ no ☐ yes ☐ unk	
2. Measurements	I. Head circumference: II. Femur length: III. Abdominal circumference:	IV. Crown-rump length: V. Biparietal diameter: VI. Estimated fetal weight:
3. Oligohydramnios (Low fluid)*	☐ no ☐ yes ☐ unk *single deepest pocket <2 cm or amniotic fluid index <5 cm (or lab diagnosis)	
4. Polyhydramnios (High fluid)**	☐ no ☐ yes ☐ unk **single deepest pocket >8 cm or amniotic fluid index ≥25 cm (or lab diagnosis)	
5. Intrauterine growth restriction***	☐ no ☐ yes ☐ unk I. If yes, percentage: ____________________________ *** AC/EFW < 3rd percentile	
6. Placental abnormality	☐ no ☐ yes ☐ unk I. If yes: ☐ Placenta previa ☐ Other, specify _________________________	
7. Anatomic abnormalities	☐ no ☐ yes ☐ unk I. If yes: ☐ Neural tube defect, specify _______________ ☐ Heart defect, specify ____________________ ☐ Polydactyly, specify ______________________ ☐ Cleft palate ☐ Cerebral anomaly, specify ____________________ ☐ Other, specify __________________________	
8. Other Abnormalities	☐ no ☐ yes ☐ unk I. If yes, describe:	

IMMUNIZATIONS

RELEVANT IMMUNIZATIONS
1. Received an Influenza vaccine in this season? ☐ yes ☐ no ☐ unknown I. If yes, date(s) of immunization – if available: ____________________________________(dd.mmm.yyyy)
2. Received a TDAP vaccine this pregnancy? ☐ yes ☐ no ☐ unknown II. If yes, date(s) of immunization – if available:____________________________________(dd.mmm.yyyy)
3. History of COVID vaccine? ☐ yes ☐ no ☐ unknown In pregnancy? ☐ yes ☐ no ☐ unknown III. If yes, which vaccine? ________________________ IV. If yes, date(s) of immunization – if available:____________________________________(dd.mmm.yyyy)
4. Has the case received any other vaccines during pregnancy? ☐ yes ☐ no ☐ unknown V. If yes, date(s) of immunization – if available:____________________________________(dd.mmm.yyyy)

PREGNANCY LOSS

NOTE: Please complete in the event of pregnancy loss. If multiple fetuses, specify fetus A/B/C.

1. Date of diagnosis of intrauterine fetal demise/ miscarriage/ or termination: _______________
2. Gestational age a time of loss: _____________ weeks

3. Elective termination? ☐ no ☐ yes
4. Spontaneous termination? ☐ no ☐ yes
5. Still birth / intrauterine demise (greater than 20 weeks)? ☐ no ☐ yes
   I. If yes: ☐ antepartum ☐ intrapartum ☐ unknown

6. Autopsy completed? ☐ no ☐ yes ☐ unknown

7. Examination findings:

8. Pathologic including cytogenetic diagnoses:

9. Cause of death:

SARS-COV-2 Products of loss testing? ☐ no ☐ yes ☐ unk	Collection Date / Time (dd.mmm.yyyy / hh.mm)	Lab Report Date (dd.mmm.yyyy)	Test	Result
☐ decidua ☐ placenta ☐ cord blood ☐ fetal blood ☐ fetal swabs ☐ Other, specify______________				☐ Pos ☐ Neg ☐ Indeterminate ☐ Unknown

INTRAPARTUM DATA COLLECTION FORMS

DELIVERY INFORMATION - MATERNAL

1. **Symptoms intrapartum** ☐ no- asymptomatic ☐ yes ☐ unk		
I. Fever ☐ no ☐ yes ☐ unk ☐ < 38°C ☐ 38-39°C ☐ >39°C ☐ Unk	II. Cough ☐ no ☐ yes ☐ unk	III. Headache ☐ no ☐ yes ☐ unk
IV. Shortness of breath ☐ no ☐ yes ☐ unk	V. Runny nose ☐ no ☐ yes ☐ unk	VI. Muscle pain/myalgia ☐ no ☐ yes ☐ unk
VII. Anorexia (loss of appetite) ☐ no ☐ yes ☐ unk	VIII. Diarrhea ☐ no ☐ yes ☐ unk	IX. Vomiting ☐ no ☐ yes ☐ unk
X. Malaise ☐ no ☐ yes ☐ unk	XI. Fatigue ☐ no ☐ yes ☐ unk	XII. Anosmia or ageusia (loss of smell or taste): ☐ no ☐ yes ☐ unk
XIII. Sore throat ☐ no ☐ yes ☐ unk	XIV. Sputum production ☐ no ☐ yes ☐ unk	XV. Nausea ☐ no ☐ yes ☐ unk
XVI. Non-specific respiratory symptoms ☐ no ☐ yes ☐ unk	XVII. Other Sx:_______________ ☐ no ☐ yes ☐ unk	XVIII. Other Sx: ______________ ☐ no ☐ yes ☐ unk

2. **Number of fetuses:** ☐ 1 ☐ 2 ☐ 3+

3. **Outcome of pregnancy:** ☐ Pregnancy loss (<20 weeks or <500g) **Complete Pregnancy Loss Form**
   ☐ Stillbirth (>20 weeks or >500g) **Complete Pregnancy Loss Form**
   ☐ Live birth
   ☐ Unknown *Note: If multiples with differing outcomes, contact coordinating centre

4. **Labour:**

☐ No labour
☐ Spontaneous
☐ Induced, indication: ☐ Antepartum hemorrhage ☐ Chorioamnionitis ☐ Suspected fetal compromise ☐ Pre-labour rupture of membranes ☐ Postdates ☐ Unknown ☐ Autoimmune disease ☐ Intrauterine growth restriction ☐ Oligohydramnios ☐ COVID-19 ☐ Other, specify: ______________________
☐ Unknown

5. **Type of anesthesia**: ☐ None ☐ Spinal ☐ Epidural ☐ Entonox ☐ General-intubated
   ☐ Unk ☐ Other, specify:____________________

6. **Mode**: ☐ vaginal ☐ C/S: ☐ elective ☐ urgent ☐ emergent C/S, indication: ____________________

7. **Length of rupture of membrane:** (HH) ______ (MM) ______

8. **Delivery complications**

I. Transfusion	☐ no	☐ yes	☐ unknown
II. Chorioamnionitis	☐ no	☐ yes	☐ unknown
III. Highest temperature recorded:	_______ °C		
IV. Fever in labour (37.5°C+ or documented fever)	☐ no	☐ yes If available, highest temperature recorded:_______ °C	☐ unknown

a. Reason for fever in labour:
☐ Asymptomatic fever (e.g., misoprostol)
☐ Symptomatic fever, OB related (chorioamnionitis, endometritis)
☐ Sepsis, OB related (chorioamnionitis, endometritis)
☐ COVID-related fever
☐ Other reason for fever, specify:______________________________
☐ Unknown

II. Other delivery complications	☐ no	☐ yes	☐ unknown

If yes, Describe: ____

9. **Were cultures done for any reason?** ☐ no ☐ yes, describe below ☐ unknown

Urine, blood, resp	Date / time collected	Result
i. _______________	Date: Time:	☐ neg ☐ pos ☐ unk Pathogen(s): ______________________________
ii. ______________	Date: Time:	☐ neg ☐ pos ☐ unk Pathogen(s): ______________________________

10. **Maternal transfer/ discharge:**

☐ Transfer to postpartum ward then discharged home

☐ Transfer to different ward; Reason: ______________________

☐ Maternal death (complete maternal death form)

☐ Transfer to other organization

☐ Transfer to ICU/CCU
*Complete hospitalization form

☐ Unknown

11. **Maternal discharge date (if applicable):** ________________________

Postpartum Medications for COVID Intrapartum Through Discharge - Maternal

NOTE: Record other medications on General Medications form

OVER THE COUNTER MEDICATIONS: ☐ No over the counter medications ☐ Unknown

1. ☐ OTC meds (check all taken)

   ☐ Acetaminophen (Tylenol)

   ☐ NSAIDS

      ☐ Acetylsalicylic acid (Aspirin)

      ☐ Ibuprofen (Advil, Motrin, others)

      ☐ Naproxen (Aleve, Naprosyn, others)

      ☐ Other ____________________

      ☐ Other____________________

   ☐ Other: _________________________

PRESCRIPTION MEDICATIONS: ☐ No prescription medications ☐ Unknown

2. ☐ Corticosteroids (check all taken)			
☐ Dexamethasone	☐ Clinical trial?	Dose:	Duration:
☐ Other, specify _________________	☐ Clinical trial?	Dose:	Duration:
☐ Other, specify _________________	☐ Clinical trial?	Dose:	Duration:
3. ☐ Chloroquine. If yes, describe circumstance:	☐ Clinical trial?	Dose:	Duration:
4. ☐ Hydroxychloroquine. If yes, describe circumstance:	☐ Clinical trial?	Dose:	Duration:
5. ☐ Colchicine	☐ Clinical trial?	Dose:	Duration:

6. ☐ Antiviral (check all taken)			
☐ Kaletra (Lopinavir/Ritonavir)	☐ Clinical trial?	Dose:	Duration:
☐ Remdesivir	☐ Clinical trial?	Dose:	Duration:
☐ Other, specify ______________________	☐ Clinical trial?	Dose:	Duration:
☐ Other, specify ______________________	☐ Clinical trial?	Dose:	Duration:
7. ☐ Antibiotics (check all taken)			
☐ Specify ______________________	☐ Clinical trial?	Dose:	Duration:
☐ Specify ______________________	☐ Clinical trial?	Dose:	Duration:
8. ☐ Other __________________________	☐ Clinical trial?	Dose:	Duration:
9. ☐ Other __________________________	☐ Clinical trial?	Dose:	Duration:
10. ☐ Other __________________________	☐ Clinical trial?	Dose:	Duration:
NATURAL HEALTH PRODUCTS FOR COVID: ☐ No natural health products ☐ Unknown			
11. ☐ Natural health products	☐ Specify __________________________ ☐ Specify __________________________ ☐ Specify __________________________ ☐ Specify __________________________		

INFANT: DELIVERY THROUGH DISCHARGE

1. ▢ Singleton ▢ Twin ▢ Other, specify _______________ *If multiples, please add additional pages*
2. If non-singleton delivery, information below is for: ▢ N/a ▢ Baby A ▢ Baby B ▢ Baby C
3. Date of birth (dd.mmm.yyyy) _____________ Time of birth (HH:MM): _________________
4. Place of birth: ▢ Hospital ▢ Home ▢ Other:______________ ▢ Unknown
5. Iatrogenic preterm birth? ▢ no ▢ yes ▢ Unk
6. **Spontaneous preterm birth?** ▢ no ▢ yes ▢ Unk
7. Umbilical Cord pH (arterial): ______________ Base excess: _______________
8. Discharge Date of Infant (dd.mmm.yyyy): _____________________
   (If not admitted to NICU for symptoms or different from maternal discharge date)

PLACENTA TESTING

9. Placental Pathology, including cytogenetics done? ▢ no ▢ yes ▢ unknown

   If yes: ▢ normal ▢ abnormal

   Describe result:____

10. **Was placenta testing for SARS-COV-2 done?** ▢ no ▢ yes; if yes, describe below ▢ unknown

Specimen	Collection Date / Time (dd.mmm.yyyy / hh:mm)	Lab Report Date (dd.mmm.yyyy)	Test	Result
I. SARS-COV-2 Placenta testing	Date: Time:			▢ Pos ▢ Neg ▢ Indeterminate ▢ Pending ▢ Unknown

DELIVERY ROOM MANAGEMENT (within first 30 minutes of life)

1. **APGARs**

   1 min ____________ 5 min ____________ 10 min ____________ ☐ 10min not done

   Any oxygen & resuscitation needs? ☐ yes ☐ no ☐ unk If yes:

   I. Free flow ☐ Unknown ☐ no ☐ yes, describe: ____________________________________
   II. IPPV per mask ☐ Unknown ☐ no ☐ yes, describe: ____________________________________
   III. Intubation ☐ Unknown ☐ no ☐ yes, describe: ____________________________________
   IV. CPAP ☐ Unknown ☐ no ☐ yes, describe: ____________________________________
   V. CPR ☐ Unknown ☐ no ☐ yes, describe: ____________________________________
   VI. Other ☐ Unknown ☐ no ☐ yes, describe: ____________________________________

2. **Birth weight:** _____________ lbs+oz / gm (circle) ☐ Unknown

3. **Birth length:** _____________ in/cm (circle) ☐ Unknown

4. **Birth head Circ:** _____________ in/cm (circle) ☐ Unknown

5. **Delayed cord clamping:** ☐ no ☐ yes ☐ unknown

   I. If yes, duration (seconds): _______________

6. **Initial physical examination**

   I. Date & time (leave blank if done at birth) _________________

   II. Respiratory exam ☐ normal ☐ abnormal ☐ not checked

   If abnormal: ☐ tachypnea ☐ dyspnea ☐ cyanosis

   III. Cardiovascular system ☐ normal ☐ abnormal ☐ not checked

   If abnormal: ☐ poorly perfused ☐ heart murmur ☐ cyanosis

   IV. Abdominal system ☐ normal ☐ abnormal ☐ not checked

   If abnormal: ☐ hepatomegaly ☐ splenomegaly

V. Neurological system ☐ normal ☐ abnormal ☐ not checked

If abnormal: ☐ tone ☐ tendon reflexes ☐ power

VI. Genitalia ☐ male ☐ female ☐ ambiguous

VII. Dysmorphism ☐ no ☐ yes ☐ Unknown

If yes, please describe ____

VIII. Any other significant findings? ☐ no ☐ yes ☐ Unknown

If yes, Please describe: ____

7. **Screening for other infectious diseases?** ☐ no ☐ yes ☐ unknown
   I. Specify _____________ Date: ___________ ☐ positive/abnormal ☐ negative/normal ☐ unknown
   II. Specify _____________ Date: ___________ ☐ positive/abnormal ☐ negative/normal ☐ unknown
   III. Specify _____________ Date: ___________ ☐ positive/abnormal ☐ negative/normal ☐ unknown

8. **Blood count**: ☐ no ☐ yes, date/time (if available): __________________ ☐ unknown
   I. ☐ positive/abnormal, specify __________________ ☐ negative/normal ☐ unknown

9. **Other investigations?** ☐ no ☐ yes ☐ unknown
   I. Specify _____________ Date: ___________ ☐ positive/abnormal ☐negative/normal ☐ unknown
   II. Specify _____________ Date: ___________ ☐ positive/abnormal ☐negative/normal ☐ unknown
   III. Specify _____________ Date: ___________ ☐ positive/abnormal ☐negative/normal ☐ unknown

10. **Any infant health events / issues between birth and discharge:** ☐ yes ☐ no ☐ unknown
   I. Jaundice ☐ no ☐ yes, describe: ____ ☐ unknown
   Ia. Phototherapy: □ no □ yes □ unknown
   II. Seizures ☐ no ☐ yes, describe: ____ ☐ unknown
   III. Hypoglycemia (glucometer <2.6mmol/L) ☐ no ☐ yes, describe below ☐ unknown

   ____
   IV. Infant death ☐ no ☐ yes *If yes, please complete infant death form ☐ unknown
   V. Admission to NICU ☐ no ☐ yes (Complete NICU form, including all diagnoses in NICU) ☐ unknown
   VI. Other ☐ no ☐ yes, describe __________________________________ ☐ unknown

11. **Infant Management:**

- ▢ A) Mother asymptomatic or mild symptoms: able to do self care out of hospital/ not hospitalized for COVID:
  - ▢ Baby in joint isolation with mother in postpartum: with skin-to-skin contact and/or breastfeeding
  - ▢ Asymptomatic baby isolated away from mum: # of days isolated ________
    -> Location of baby isolation: ▢ Postpartum ward ▢ Special Care Nursery or NICU ▢ Other: ____
  - ▢ Symptomatic baby transferred to SCN or NICU care
- ▢ B) Mother symptomatic requires ongoing hospitalization for management of COVID, but not critical care:
  - ▢ Baby in joint isolation with mother in postpartum: with skin-to-skin contact and/or breastfeeding
  - ▢ Asymptomatic baby isolated away from mum: # of days isolated ________
    -> Location of baby isolation: ▢ Postpartum ward ▢ Special Care Nursery or NICU ▢ Other: ____
  - ▢ Symptomatic baby transferred to SCN or NICU care
- ▢ C) Mother in critical care for COVID:
  - ▢ Baby allowed close contact with mum - skin to skin contact or within 2 m
  - ▢ Asymptomatic baby isolated away from mum # of days isolated ________
    -> Location of baby isolation: ▢ Postpartum ward ▢ Special Care Nursery or NICU ▢ Other: ____
  - ▢ Symptomatic baby transferred to SCN or NICU care
- ▢ D) Unknown
- ▢ E) Other, specify: ____

12. **Was breastfeeding started right after birth?** ☐ no ☐ yes ☐ Unk

I. If not, at which day of life was breastfeeding started**?** ____days of life ☐ not started prior to discharge

II. Was breastfeeding delayed because COVID+ or suspected COVID+? ☐ no ☐ yes ☐ Unk

13. **Type of feeding through first 48 hours**	**Fed by mother**	**Fed by alternate health care provider or family, who is NOT currently COVID-19 positive and is NOT a contact of a current COVID-19 case**	**Fed by alternate health care provider or family, who is either currently COVID-19 positive or a contact of a current COVID-19 case**	**Unknown**
I. Breast fed	☐	N/A	N/A	☐
II. Expressed breast milk	☐	☐	☐	☐
III. Breast milk substitute – formula	☐	☐	☐	☐
IV. Donor milk	☐	☐	☐	☐
V. Intravenous and/or TPN	☐	☐	☐	☐

INFANT MEDICATIONS

14. Medications given to infant (not including those administered in NICU, complete NICU information form):

I. Erythromycin (eye prophylaxis): ☐ no ☐ yes ☐ unknown

II. Vitamin K: ☐ no ☐ yes ☐ unknown

III. Other ☐ no ☐ yes ☐ unknown -If yes, specify _____________________ Indication ________________

IV. Other ☐ no ☐ yes ☐ unknown - If yes, specify _____________________ Indication ________________

V. Other ☐ no ☐ yes ☐ unknown -If yes, specify _____________________ Indication ________________

NICU INFORMATION

1. Was there a NICU Admission ☐ no, skip section ☐ yes, go to '2'
2. If non-singleton delivery, information below is for: ☐ N/a ☐ Baby A ☐ Baby B ☐ Baby C
3. NICU admission date (dd.mmm.yyyy)_______________ 4. NICU discharge date (dd.mmm.yyyy)________________
5. Levels of NICU care needed: ☐ Level I ☐ Level II ☐ Level III ☐ not sure
6. Name of NICU providing highest level of care ____
7. Any diagnoses given in NICU? ☐ yes ☐ no ☐ unknown

I. Respiratory system:
- ☐ Respiratory distress syndrome
- ☐ Transient tachypnoea of newborn
- ☐ Meconium aspiration syndrome
- ☐ Bronchopulmonary dysplasia
- ☐ Congenital pneumonia
- ☐ None
- ☐ Ventilator-associated pneumonia
- ☐ Pneumothorax
- ☐ Pleural effusion
- ☐ Others (please describe): _____________________________

II. Cardiovascular system:
- ☐ Hypotension requiring inotropes/steroids
- ☐ Persistent pulmonary hypertension
- ☐ None
- ☐ Patent ductus arteriosus
- ☐ Myocarditis
- ☐ Others (please describe): _____________________________

III. Gastrointestinal system:
- ☐ Spontaneous intestinal perforation
- ☐ Cow's milk protein allergy
- ☐ Cholestasis (Bc>20umol/L)
- ☐ None
- ☐ Necrotising entercolitis
- ☐ Intestinal obstruction
- ☐ Elevated ALT and/or AST
- ☐ Others (please describe): _____________________________

IV. Infection:
- ☐ Culture proven sepsis
- ☐ None
- ☐ Urinary tract infection
- ☐ Others (please describe): _____________________________

V. Neurological system:
- ☐ Intraventricular haemorrhage
- ☐ Neonatal seizure
- ☐ Hydrocephalus
- ☐ None
- ☐ Periventricular leucomalacia
- ☐ Hypoxic-ischemic encephalopathy
- ☐ Others (please describe): _____________________________

VI. Hematological system: ☐ Thrombocytopenia (PLT<100x10^9/L) ☐ None ☐ Leukopenia (WBC<5x10^9/L) ☐ Others (please describe): ____________________________

8. **Care requirement at NICU**

I. Respiratory system? ☐ yes ☐ no ☐ unknown

☐ Invasive Mechanical ventilation If yes, duration (days)_________________

☐ Non-invasive ventilation If yes, duration (days) _________________

☐ Surfactant use If yes, number of doses ________________

☐ Use of inhaled nitric oxide If yes, duration (days) _________________

II. Cardiovascular system? ☐ yes ☐ no ☐ unknown

☐ ECMO (VA or VV) If yes, duration (days) _________________

III. Gastrointestinal system? ☐ yes ☐ no ☐ unknown

☐ Parenteral nutrition If yes, duration (days) _________________

☐ Surgery If yes, please describe: ________________

IV. Neurological system? ☐ yes ☐ no ☐ unknown

☐ Therapeutic hypothermia

☐ EEG

☐ Lumbar puncture for any reason If yes, key findings: _____________________

V. Imaging? ☐ yes ☐ no ☐ unknown

☐ Chest x-ray If yes, key findings:__________________________

☐ Ultrasound brain If yes, key findings: __________________________

☐ MRI brain If yes, key findings: __________________________

9. Discharged from NICU to: ☐ home ☐ hospital ☐ other, specify ______________________ ☐ Unknown

INFANT MEDICATIONS IN NICU

10. Medications given to infant in NICU:

I. Erythromycin (eye prophylaxis): ▢ no ▢ yes ▢ unknown

II. Vitamin K: ▢ no ▢ yes ▢ unknown

III. Other ▢ no ▢ yes ▢ unknown -If yes, specify ____________________ Indication _______________

IV. Other ▢ no ▢ yes ▢ unknown - If yes, specify ____________________ Indication _______________

V. Other ▢ no ▢ yes ▢ unknown -If yes, specify ____________________ Indication _______________

INFANT SARS-COV-2 TESTING

NOTE: Update with all infant SARS-CoV-2 test results

Was at least one SARS-COV-2 Lab test done in infant? ☐ Yes ☐ No ☐ Unk

1. If non-singleton delivery, information below is for: ☐ N/a ☐ Baby A ☐ Baby B ☐ Baby C

2. Specimen	Collection Date & Time (dd.mmm.yyyy/hh:mm)	Lab Report Date (dd.mmm.yyyy)	Test	Result
☐ Nasopharyngeal swab #1	Date: Time:		PCR	☐ Pos ☐ Neg ☐ Indeterminate ☐ Pending ☐ Unknown
☐ Nasopharyngeal swab #2	Date: Time:		PCR	☐ Pos ☐ Neg ☐ Indeterminate ☐ Pending ☐ Unknown
☐ Nasopharyngeal swab #3	Date: Time:		PCR	☐ Pos ☐ Neg ☐ Indeterminate ☐ Pending ☐ Unknown
☐ Throat swab	Date: Time:			☐ Pos ☐ Neg ☐ Indeterminate ☐ Pending ☐ Unknown
☐ Serology – IgM	Date: Time:			☐ Pos ☐ Neg ☐ Indeterminate ☐ Pending ☐ Unknown
☐ Serology – IgG	Date: Time:			☐ Pos ☐ Neg ☐ Indeterminate ☐ Pending ☐ Unknown
☐ Cord blood testing - IgM	Date: Time:			☐ Pos ☐ Neg ☐ Indeterminate ☐ Pending ☐ Unknown
☐ Cord blood testing- IgG	Date: Time:			☐ Pos ☐ Neg ☐ Indeterminate ☐ Pending ☐ Unknown
☐ Other testing, if clinically indicated: __________________	Date: Time:			☐ Pos ☐ Neg ☐ Indeterminate ☐ Pending ☐ Unknown

POSTPARTUM (6-8 WEEKS) DATA COLLECTION FORMS

POSTPARTUM FOLLOW-UP (6-8 WEEKS) – MATERNAL INFORMATION

1. Date (records current to, dd.mm.yyyy): ___________________

2. **COVID Symptoms Postpartum (6-8 weeks)** ☐ no- asymptomatic ☐ yes ☐ unk 3. **Date of onset (dd.mmm.yyyy) _________________________**		
I. Fever ☐ no ☐ yes ☐ unk ☐ < 38°C ☐ 38-39°C ☐ >39°C ☐ Unk	II. Cough ☐ no ☐ yes ☐ unk	III. Headache ☐ no ☐ yes ☐ unk
IV. Shortness of breath ☐ no ☐ yes ☐ unk	V. Runny nose ☐ no ☐ yes ☐ unk	VI. Muscle pain/myalgia ☐ no ☐ yes ☐ unk
VII. Anorexia (loss of appetite) ☐ no ☐ yes ☐ unk	VIII. Diarrhea ☐ no ☐ yes ☐ unk	IX. Vomiting ☐ no ☐ yes ☐ unk
X. Malaise ☐ no ☐ yes ☐ unk	XI. Fatigue ☐ no ☐ yes ☐ unk	XII. Anosmia or ageusia (loss of smell or taste): ☐ no ☐ yes ☐ unk
XIII. Sore throat ☐ no ☐ yes ☐ unk	XIV. Sputum production ☐ no ☐ yes ☐ unk	XV. Nausea ☐ no ☐ yes ☐ unk
XVI. Non-specific respiratory symptoms ☐ no ☐ yes ☐ unk	XVII. Other Sx:_______________ ☐ no ☐ yes ☐ unk	XVIII. Other Sx: ______________ ☐ no ☐ yes ☐ unk

4. Any maternal health issues since delivery?*:

- ☐ No
- ☐ Postpartum depression
- ☐ Wound infection
- ☐ Postpartum preeclampsia
- ☐ Endometritis
- ☐ Other, describe: ____
- ☐ Unknown

NOTES:

*Please update the SARS-COV-2 HISTORY, MATERNAL TESTING, SYMPTOMS, TREATMENTS, & HOSPITALIZATONS THROUGH FOLLOW-UP form as applicable: COVID symptoms (pages 5), complications (page 6), imaging (pages 6-7), treatments (page 8)

**Record maternal COVID-19 medications since discharge (or last report if home birth) below

***If additional infant SARS-CoV-2 testing or maternal SARS-CoV-2 testing is done, please update SARS-CoV-2 DCFs on the maternal testing forms and the infant testing forms

Postpartum Medications for COVID Since Discharge (or last report if home birth) - Maternal

<u>NOTE</u>: Record other medications on General Medications form

OVER THE COUNTER MEDICATIONS: ☐ No over the counter medications ☐ Unknown

1. ☐ OTC meds (check all taken)
☐ Acetaminophen (Tylenol)
☐ NSAIDS
    ☐ Acetylsalicylic acid (Aspirin)
    ☐ Ibuprofen (Advil, Motrin, others)
    ☐ Naproxen (Aleve, Naprosyn, others)
    ☐ Other ____________________
    ☐ Other____________________
☐ Other: _________________________

PRESCRIPTION MEDICATIONS: ☐ No prescription medications ☐ Unknown			
2. ☐ Corticosteroids (check all taken)			
☐ Dexamethasone	☐ Clinical trial?	Dose:	Duration:
☐ Other, specify _________________	☐ Clinical trial?	Dose:	Duration:
☐ Other, specify _________________	☐ Clinical trial?	Dose:	Duration:
3. ☐ Chloroquine. If yes, describe circumstance:	☐ Clinical trial?	Dose:	Duration:
4. ☐ Hydroxychloroquine. If yes, describe circumstance:	☐ Clinical trial?	Dose:	Duration:
5. ☐ Colchicine	☐ Clinical trial?	Dose:	Duration:

6. ☐ Antiviral (check all taken)			
☐ Kaletra (Lopinavir/Ritonavir)	☐ Clinical trial?	Dose:	Duration:
☐ Remdesivir	☐ Clinical trial?	Dose:	Duration:
☐ Other, specify ______________________	☐ Clinical trial?	Dose:	Duration:
☐ Other, specify ______________________	☐ Clinical trial?	Dose:	Duration:
7. ☐ Antibiotics (check all taken)			
☐ Specify ______________________	☐ Clinical trial?	Dose:	Duration:
☐ Specify ______________________	☐ Clinical trial?	Dose:	Duration:
8. ☐ Other __________________________	☐ Clinical trial?	Dose:	Duration:
9. ☐ Other __________________________	☐ Clinical trial?	Dose:	Duration:
10. ☐ Other __________________________	☐ Clinical trial?	Dose:	Duration:
NATURAL HEALTH PRODUCTS FOR COVID: ☐ No natural health products ☐ Unknown			
11. ☐ Natural health products	☐ Specify __________________________ ☐ Specify __________________________ ☐ Specify __________________________ ☐ Specify __________________________		

POSTPARTUM FOLLOW-UP (6-8 WEEKS) – INFANT INFORMATION

1. **If non-singleton delivery, information below is for:** ☐ N/a ☐ Baby A ☐ Baby B ☐ Baby C
2. **Any infant health events / issues since discharge (last report for home births without admission):**

I.	Poor weight gain	☐ Unk	☐ no	☐ yes, describe: ______________________________
II.	Seizures/ on antiepileptic medications	☐ Unk	☐ no	☐ yes, describe: ______________________________
III.	Bronchiolitis	☐ Unk	☐ no	☐ yes, describe: ______________________________
IV.	Constipation	☐ Unk	☐ no	☐ yes, describe: ______________________________
V.	Pneumonia	☐ Unk	☐ no	☐ yes, describe: ______________________________
VI.	Rehospitalization	☐ Unk	☐ no	☐ yes, describe: ______________________________
VII.	Acquire or relapse of COVID after discharge?	☐ Unk	☐ no	☐ yes, describe: ______________________________
VIII.	Infant death	☐ Unk	☐ no	☐ yes If yes, please complete infant death form
IX.	Other	☐ Unk	☐ no	☐ yes, describe:______________________________

INFANT FEEDING

3. **Type of feeding to date**	**Fed by mother**	**Fed by alternate health care provider or family, who is NOT currently COVID-19 positive and is NOT a contact of a current COVID-19 case**	**Fed by alternate health care provider or family, who is either currently COVID-19 positive or a contact of a current COVID-19 case**	**Unknown**
I. Breast fed	☐	N/A	N/A	☐
II. Expressed breast milk	☐	☐	☐	☐
III. Breast milk substitute – formula	☐	☐	☐	☐
IV. Donor milk	☐	☐	☐	☐
V. Intravenous and/or TPN	☐	☐	☐	☐

INFANT MEDICATIONS

4. Medications given to infant: ▢ no ▢ yes ▢ unknown If yes, complete below

I. Specify ______________________________ Indication __________________________

II. Specify ______________________________ Indication __________________________

III. Specify ______________________________ Indication __________________________

IV. Specify ______________________________ Indication __________________________

V. Specify ______________________________ Indication __________________________

1 YEAR INFANT FOLLOW-UP DATA COLLECTION FORMS

ONE YEAR INFANT FOLLOW-UP INFORMATION

1. **Date (records current to, dd.mm.yyyy):** ____________________

2. **If non-singleton delivery, information below is for:** ☐ N/a ☐ Baby A ☐ Baby B ☐ Baby C

3. **Any infant health events / issues since 6-8 week follow-up):**

I.	Poor weight gain / failure-to-thrive	☐ Unk	☐ no	☐ yes, describe: ______________________________
II.	Anaphylaxis	☐ Unk	☐ no	☐ yes, describe: ______________________________
III.	Allergic rhinitis	☐ Unk	☐ no	☐ yes, describe: ______________________________
IV.	Kawasaki disease	☐ Unk	☐ no	☐ yes, describe: ______________________________
V.	Asthma	☐ Unk	☐ no	☐ yes, describe: ______________________________
VI.	Need for home oxygen for any duration	☐ Unk	☐ no	☐ yes, describe: ______________________________
VII.	Diabetes mellitus	☐ Unk	☐ no	☐ yes, describe: ______________________________
VIII.	Hypothyroidism	☐ Unk	☐ no	☐ yes, describe: ______________________________
IX.	Renal failture requiring replacement therapy	☐ Unk	☐ no	☐ yes, describe: ______________________________
X.	Hypertension	☐ Unk	☐ no	☐ yes, describe: ______________________________
XI.	Glomerulonephritis	☐ Unk	☐ no	☐ yes, describe: ______________________________
XII.	Urinary tract infection	☐ Unk	☐ no	☐ yes, describe: ______________________________
XIII.	Culture proven bacteremia	☐ Unk	☐ no	☐ yes, describe: ______________________________
XIV.	Meningitis	☐ Unk	☐ no	☐ yes, describe: ______________________________
XV.	Otitis media	☐ Unk	☐ no	☐ yes, describe: ______________________________
XVI.	Acute bronchitis	☐ Unk	☐ no	☐ yes, describe: ______________________________
XVII.	Acute bronchiolitis	☐ Unk	☐ no	☐ yes, describe: ______________________________
XVIII.	Pneumonia, any organism	☐ Unk	☐ no	☐ yes, describe: ______________________________
XIX.	Upper respiratory infection	☐ Unk	☐ no	☐ yes, describe: ______________________________

XX.	Any infection caused by Escherichia coli	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXI.	Any infection caused by Haemophilus influenzae	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXII.	Any infection caused by Klebsiella pneumoniae	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXIII.	Any infection caused by Streptococcus	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXIV.	Any infection caused by Staphylococcus	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXV.	Enterovirus infection	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXVI.	Gastroenteritis	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXVII.	Constipation	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXVIII.	Hand-Foot-and-Mouth Disease	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXIX.	Herpes simplex	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXX.	Respiratory syncytical virus	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXXI.	Varicella (chickenpox)	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXXII.	Seizures/ on antiepileptic medications	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXXIII.	Rehospitalization	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXXIV.	Acquire or relapse of COVID after 6-8 week follow-up?	☐ Unk	☐ no	☐ yes, describe: ______________________________
XXXV.	Infant death	☐ Unk	☐ no	☐ yes If yes, please complete infant death form
XXXVI.	Other	☐ Unk	☐ no	☐ yes, describe: ______________________________

INFANT FEEDING

4. Type of feeding to date	Fed by mother	Fed by alternate health care provider or family, who is NOT currently COVID-19 positive and is NOT a contact of a current COVID-19 case	Fed by alternate health care provider or family, who is either currently COVID-19 positive or a contact of a current COVID-19 case	Unknown
I. Breast fed	☐	N/A	N/A	☐
II. Expressed breast milk	☐	☐	☐	☐
III. Breast milk substitute – formula	☐	☐	☐	☐
IV. Donor milk	☐	☐	☐	☐
V. Intravenous and/or TPN	☐	☐	☐	☐

INFANT MEDICATIONS

I. **Antihistamine** ☐ Unk ☐ no ☐ yes
(Examples: Atarax (hydroxyzine); Reactine (cetirizine); Rupall (rupatadine); Blexten (bilastine)
If yes, duration: ☐ <1 week ☐ 1-2 weeks ☐ 3-4 weeks ☐ >4 weeks

Specify: ____________________

II. **Beta-agonists or inhaled bronchodilators** ☐ Unk ☐ no ☐ yes
(Examples: Ventolin (salbutamol); Bricanyl (terbutaline)
If yes, duration: ☐ <1 week ☐ 1-2 weeks ☐ 3-4 weeks ☐ >4 weeks

Specify: ____________________

III. **Inhaled corticosteroids** ☐ Unk ☐ no ☐ yes
If yes, duration: ☐ <1 week ☐ 1-2 weeks ☐ 3-4 weeks ☐ >4 weeks

Specify: ____________________

IV. **Intranasal corticosteroids** ☐ Unk ☐ no ☐ yes
If yes, duration: ☐ <1 week ☐ 1-2 weeks ☐ 3-4 weeks ☐ >4 weeks

Specify: _____________________

V. **Systemic corticosteroids** (Examples: dexamethasone, prednisone, hydrocortisone) ☐ Unk ☐ no ☐ yes
If yes, duration: ☐ <1 week ☐ 1-2 weeks ☐ 3-4 weeks ☐ >4 weeks

Specify: _____________________

VI. **Any medications for endocrine-related disorders** (Examples: Desmopressin, Diazoxide, Glucagon, Growth hormone, Insulin, Lupron, Octreotide, Testosterone, Thyroxine) ☐ Unk ☐ no ☐ yes
If yes, duration: ☐ <1 week ☐ 1-2 weeks ☐ 3-4 weeks ☐ >4 weeks

Specify: _____________________

VII. Any anti-hypertensive medication ☐ Unk ☐ no ☐ yes
If yes, duration: ☐ <1 week ☐ 1-2 weeks ☐ 3-4 weeks ☐ >4 weeks

Specify: _____________________

VIII. Any antibiotics ☐ Unk ☐ no ☐ yes
If yes, duration: ☐ <1 week ☐ 1-2 weeks ☐ 3-4 weeks ☐ >4 weeks

Specify: _____________________

IX. Any probiotics (prescribed or over-the-counter) ☐ Unk ☐ no ☐ yes
If yes, duration: ☐ <1 week ☐ 1-2 weeks ☐ 3-4 weeks ☐ >4 weeks

Specify: _____________________

X. Other 1 ☐ Unk ☐ no ☐ yes
If yes, duration: ☐ <1 week ☐ 1-2 weeks ☐ 3-4 weeks ☐ >4 weeks

Specify: _____________________

XI. Other 2 ☐ Unk ☐ no ☐ yes
If yes, duration: ☐ <1 week ☐ 1-2 weeks ☐ 3-4 weeks ☐ >4 weeks

Specify: _____________________

MATERNAL DEATH

NOTE: Please complete this form in the event of a maternal death.

1. Date of death (dd.mmm.yyyy)	
2. Probable cause of death as per clinical report (Describe):	
3. Autopsy completed? ☐ no ☐ yes	
4. Examination date (dd.mmm.yyyy):	
5. Examination findings:	
6. Pathologic diagnoses:	
7. Cause of death as per autopsy report:	

INFANT DEATH

<u>NOTE</u>: Please complete this form in the event of an infant death.

1. If multiples, this form refers to**:** ☐ N/a ☐ Baby A ☐ Baby B ☐ Baby C

2. Postnatal age in calendar days (Age of infant in hours, if <24 hours, add "h" at the end):	
3. Probable cause of death as per clinical report (Describe):	
4. Autopsy completed? ☐ no ☐ yes	
5. Examination date (dd.mmm.yyyy):	
6. Examination findings:	
7. Pathologic diagnoses:	
8. Cause of death as per autopsy report	

ID: CCP-______- ______

GENERAL MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER) & SUPPLEMENTS FORM - MATERNAL

NOTES:

- For any medications/supplements taken related to COVID, in pregnancy, intrapartum or 6-8 weeks postpartum, complete respective forms above. For all other medications (maternal) complete this table.
- For any medications/supplements given to infant, either related to COVID, in the case of a NICU admission, or generally, please complete in respective sections above.

I. MEDICATIONS / SUPPLEMENTS DURING PREGNANCY ☐ **No medications / supplements taken at any time during pregnancy, other than for COVID as indicated on above forms** ☐ **Unknown**	
Specify Medication / Supplement	**Indication (Reason Given)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
II. MEDICATIONS / SUPPLEMENTS INTRAPARTUM (DURING LABOUR UNTIL DELIVERY) ☐ **No medications / supplements taken at any time intrapartum, other than for COVID as indicated on above forms** ☐ **Unknown**	
Specify Medication / Supplement	**Indication (Reason Given)**
1.	
2.	
3.	
4.	

5.	
6.	
7.	
8.	
9.	
10.	

III. MEDICATIONS / SUPPLEMENTS POSTPARTUM UNTIL 6-8 WEEKS FOLLOW-UP

- ☐ **No medications / supplements taken at any time postpartum until 6-8 weeks follow-up, other than for COVID as indicated on above forms**
- ☐ **Unknown**

Specify Medication / Supplement	**Indication (Reason Given)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	