ID Number:

UKOSS

UK Obstetric Surveillance System

Pregnancy at advanced maternal age Study 03/13

Data Collection Form - CASE

Please report any women delivering on or after 01/07/2013 and before 01/07/2014

Case Definition:

Please report any pregnant woman of 20 weeks gestation or more, who is aged 48 years or older at the estimated date of delivery.

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: _____

npeu National Perinatal Epidemiology Unit

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 Y Y Y Y

1.2 Age at estimated date of delivery (EDD) ☐☐

1.3 Age at actual date of delivery ☐☐

1.4 Ethnic group[1]* *(enter code, please see back cover for guidance)* ☐☐

1.5 Marital status single ☐ married ☐ cohabiting ☐

1.6 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 _____

1.7 Height at booking ☐☐☐ cm

1.8 Weight at booking ☐☐☐.☐ kg

1.9 Smoking status never ☐ gave up prior to pregnancy ☐ current ☐ gave up during pregnancy ☐

Section 2: Previous Obstetric History

2.1 Gravidity

Number of completed pregnancies beyond 24 weeks ☐☐

Number of live births ☐☐

Number of stillbirths ☐☐

Please give date of delivery of the most recent completed pregnancy beyond 24 weeks: D D / M M / Y Y

Number of pregnancies less than 24 weeks ☐☐

Number of miscarriages ☐☐

Number of terminations of pregnancy ☐☐

Number of ectopic pregnancies ☐☐

Please give the end date of the most recent pregnancy less than 24 weeks: D D / M M / Y Y

If no previous pregnancies, *please go to section 3.*

*For guidance please see back cover

2.2 **Has the woman had any previous caesarean sections?** Yes ☐ No ☐

If Yes, please specify number in total ☐☐

2.3 **Were any of the following present in previous pregnancies?** Yes ☐ No ☐

If Yes, please tick all that apply

Pregnancy induced hypertension ☐ Pre-eclampsia ☐ Eclampsia ☐

Gestational diabetes ☐ Postpartum haemorrhage ☐ Placenta praevia ☐

Placental abruption ☐ Preterm (<37 weeks) birth ☐ Macrosomia (birthweight >=4.5kg) ☐

2.4 **Did the woman have any other previous pregnancy problems?[2]*** Yes ☐ No ☐

If Yes, please specify _____

Section 3: Previous Medical History

3.1 **Has the woman had any other previous uterine surgery** *(e.g. ERPC, myomectomy, manual removal of placenta)* Yes ☐ No ☐

3.2 **Please indicate whether the woman had any of the following previous or pre-existing medical conditions:**

Essential hypertension	Requiring medication ☐	Not requiring medication ☐	No ☐
Diabetes mellitus	Type 1 ☐	Type 2 ☐	No ☐
Renal disease		Yes ☐	No ☐
Hypercholesterolemia		Yes ☐	No ☐
Antiphospholipid syndrome		Yes ☐	No ☐
Other thrombophilia (e.g. Factor V Leiden)		Yes ☐	No ☐
Previous thrombotic event (e.g. DVT/PE)		Yes ☐	No ☐
Ischaemic heart disease		Yes ☐	No ☐
Other cardiac disease		Yes ☐	No ☐

3.3 **Did the woman have any other previous or pre-existing medical problems?[3]*** Yes ☐ No ☐

If Yes, please give details _____

Section 4: This Pregnancy

4.1 **Final Estimated Date of Delivery (EDD)[4]*** D D / M M / Y Y

4.2 **Was this pregnancy a multiple pregnancy?** Yes ☐ No ☐

If Yes, specify number of fetuses ☐

4.3 **Date of first booking visit** D D / M M / Y Y

4.4 **Was this a planned pregnancy?** Yes ☐ No ☐ Not known ☐

4.5 **Was this pregnancy conceived following assisted conception?** Yes ☐ No ☐ Not known ☐

If Yes,

Where was the assisted conception performed?	UK ☐	Abroad ☐	Not known ☐
Was egg donation used?	Yes ☐	No ☐	Not known ☐
Was sperm donation used?	Yes ☐	No ☐	Not known ☐
Did the women have IVF/ICSI?	Yes ☐	No ☐	Not known ☐

If Yes, how many embryos were transferred? ☐

*For guidance please see back cover

4.6 **At booking, was the plan for more than the recommended (NICE or equivalent guidance) number of antenatal visits for low risk women?** Yes ☐ No ☐

If Yes, please indicate below the reasons for this *(tick all that apply)*

Underlying medical condition ☐ Maternal age ☐ Other ☐

If Other, please specify _____

4.7 **Was antenatal care undertaken in the usual hospital for this woman's area of residence?** Yes ☐ No ☐

If No, please indicate below reasons for care at a different hospital *(tick all that apply)*

Referred to a tertiary centre because of underlying medical condition ☐

Patient preference ☐ Maternal age ☐ Other ☐

If Other, please specify _____

4.8 **Was the woman on any medications at the first booking visit?** Yes ☐ No ☐

If Yes, complete the table below

Name of medication	Medication continued	Date stopped
	Yes ☐ No ☐	D D / M M / Y Y
	Yes ☐ No ☐	D D / M M / Y Y
	Yes ☐ No ☐	D D / M M / Y Y

4.9 **Did this woman consent to have antenatal screening for chromosomal or structural abnormalities?** Yes ☐ No ☐

If Yes, which of the following tests did the women have *(tick all that apply)*

Nuchal translucency ☐ Biochemistry ☐ Chorionic villus sampling (CVS) ☐

Amniocentesis ☐ 18-20 week scan ☐

4.10 **Did the woman develop gestational diabetes?** Yes ☐ No ☐

If Yes,

What was the date of diagnosis? D D / M M / Y Y

How was she managed? *(tick all that apply)*

Diet alone ☐ Oral hypoglycaemic agents ☐ Insulin ☐

4.11 **Did the woman develop any hypertensive disorder?** Yes ☐ No ☐

If Yes, please specify

		Date of onset	Time of onset
Pregnancy induced hypertension	☐	D D / M M / Y Y	
Pre-eclampsia (hypertension and proteinuria)	☐	D D / M M / Y Y	
Eclampsia	☐	D D / M M / Y Y	h h : m m (24hr)
Other	☐	D D / M M / Y Y	

If Other, please specify _____

How was she managed? *(tick all that apply)*

Antihypertensive medication ☐ Magnesium sulphate ☐ Early delivery ☐

4.12 **Did the women receive aspirin in this pregnancy?** Yes ☐ No ☐

If Yes, was aspirin started during this pregnancy? Yes ☐ No ☐

If Yes, please give the date when aspirin was started D D / M M / Y Y

4.13 Did the woman receive any antenatal thromboprophylaxis in this pregnancy? Yes ☐ No ☐

If Yes, tick all that were used:

TED stockings ☐ Antiplatelet agent (other than aspirin) ☐ Low molecular weight heparin ☐
Unfractionated heparin ☐ Warfarin ☐ Other ☐

If Other, please specify _____

4.14 Did the woman have a thrombotic event antenatally or postnatally in this pregnancy? (e.g. DVT/PE) Yes ☐ No ☐

If Yes, was this:

		Date of event
PE	☐	D D / M M / Y Y
DVT	☐	D D / M M / Y Y
Other, please specify _____	☐	D D / M M / Y Y

4.15 Was placenta praevia diagnosed? Yes ☐ No ☐

If Yes, was this diagnosed Prior to delivery ☐ During delivery ☐

Please specify the grade ☐

4.16 Did the woman have a placental abruption? Yes ☐ No ☐

4.17 Did the woman have a 3rd trimester ultrasound examination performed? Yes ☐ No ☐

If Yes, please state indication _____

4.18 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 D D / M M / Y Y

5.2 Did this woman have a termination of pregnancy? Yes ☐ No ☐

If Yes, please specify

Date of termination D D / M M / Y Y

Indication for termination _____

If Yes to 5.1 or 5.2, *please now complete 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 the name of the hospital providing future care

_____

Will she be delivered at your hospital? Yes ☐ No ☐

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

_____

5.4 Was delivery induced? Yes ☐ No ☐

If Yes, when was induction commenced? D D / M M / Y Y h h : m m (24hr)

Was maternal age the primary indication for induction? Yes ☐ No ☐

If No, what was the indication? _____

5.5 Did the membranes rupture before delivery? Yes ☐ No ☐

If Yes, what was the date and time of membrane rupture? D D / M M / Y Y h h : m m (24hr)

*For guidance please see back cover

5.6 Did the woman labour? Yes ☐ No ☐

If Yes, what date and time was labour diagnosed? D D / M M / Y Y h h : m m (24hr)

Was labour augmented with syntocinon? Yes ☐ No ☐

If Yes, please state duration of syntocinon h h : m m (24hr)

5.7 Was delivery by caesarean section? Yes ☐ No ☐

If Yes, please state:

Grade of urgency[5]* ☐

Method of anaesthesia: Regional ☐ General anaesthetic ☐

Was maternal age the primary indication for caesarean section? Yes ☐ No ☐

If No, what was the indication? _____

5.8 What was the estimated total blood loss at delivery (mls)? ☐☐☐☐☐

5.9 Did the woman have diagnosed postpartum haemorrhage? Yes ☐ No ☐

If Yes, what was the primary underlying cause of haemorrhage? *(tick one only)*

Uterine atony ☐ Placenta accreta/increta/percreta ☐ Placenta praevia ☐

Placental abruption ☐ Uterine infection ☐ Uterine rupture ☐

Genital tract trauma/tears ☐ Other ☐

If Other, please specify _____

5.10 Did the woman refuse blood products? Yes ☐ No ☐

If No, were blood products given? Yes ☐ No ☐

5.11 Were thromboprophylactic measures used after delivery? Yes ☐ No ☐

If Yes, please tick all that were used TED stockings ☐ Antiplatelet agent (e.g. aspirin) ☐

Low molecular weight heparin ☐ Pneumatic compression stockings ☐

Unfractionated heparin ☐ Warfarin ☐ Other ☐

If Other, please specify _____

Section 6: Outcomes

Section 6a: Woman

6a.1 Was the woman admitted to ITU (critical care level 3)? Yes ☐ No ☐

If Yes, please specify:

Duration of stay ☐☐ days

Or Tick if woman is still in ITU ☐

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 D D / M M / Y Y h h : m m (24hr)

What was the primary cause of death as stated on the death certificate?

(Please state if not known) _____

Was a post mortem examination undertaken?

If Yes, did the examination confirm the cause of death? Yes ☐ No ☐ Not known ☐

*For guidance please see back cover

Section 6b: Infant

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 D D / M M / Y Y h h : m m (24hr)

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, was this? Ante-partum ☐ Intra-partum ☐

If Yes, *go to section 7*

6b.6 5 min Apgar ☐☐

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

6b.8 Did the infant have a congenital anomaly including chromosomal or structural abnormalities? Yes ☐ No ☐

If Yes, please specify _____

6b.9 Did any major infant complications occur?[7*] Yes ☐ No ☐ Unknown ☐

If Yes, please specify _____

6b.10 Did this infant die? Yes ☐ No ☐

If Yes, please specify date and time of death D D / M M / Y Y h h : m m (24hr)

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 D D / M M / Y Y

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:

Acute fatty liver
Amniotic fluid embolism
Polyhydramnios
Placenta accreta/increta/percreta
Neonatal death
Baby with a major congenital abnormality
Small for gestational age (SGA) infant
Large for gestational age (LGA) infant
Infant requiring intensive care
Puerperal psychosis
Surgical procedure in pregnancy
Significant antepartum haemorrhage
Hyperemesis requiring admission
Dehydration requiring admission
Ovarian hyperstimulation syndrome
Severe infection e.g. pyelonephritis

3. Previous or pre-existing maternal medical problems, including:

Autoimmune diseases
Cancer
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
Polycystic ovary disease
Addictive disorders

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 morbidity, including:

Persistent vegetative state
Cardiac arrest
Cerebrovascular accident
Adult respiratory distress syndrome
Disseminated intravascular coagulopathy
Pulmonary oedema
Mendleson's syndrome
Multiple organ failure
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
Severe infection e.g. septicaemia, meningitis
Exchange transfusion