ID Number:

UKOSS

UK Obstetric Surveillance System

COVID-19 in Pregnancy
Study 03/20

Data Collection Form - CASE

Please report all pregnant women admitted on or after 1st March 2020

and before 31st July 2021

Case Definition:

Any woman admitted to hospital with presumed or confirmed COVID-19 infection in pregnancy.

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 617764 / 617774

Case reported in: _____

NPEU

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

1.3 Marital status single ☐ married ☐ cohabiting ☐

1.4 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

_____

1.5 Height at booking ☐☐☐ cm

1.6 Weight at booking ☐☐☐.☐ kg

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

Section 2: Previous Obstetric History

2.1 Gravidity

Number of previous completed pregnancies beyond 24 weeks ☐☐

Number of previous pregnancies less than 24 weeks ☐☐

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

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

If Yes, please specify _____

*For guidance please see back cover

Section 3: Previous Medical History

3.1 **Does the woman have asthma requiring regular inhaled or oral steroids?** Yes ☐ No ☐

3.2 **Has the woman had any other previous or pre-existing medical problems?[3]*** Yes ☐ No ☐

If Yes, please specify _____

3.3 **Has the woman ever been immunised against Covid-19?** Yes ☐ No ☐

If Yes, what type of vaccine did she receive?

Pfizer BioNTech ☐ Oxford AstraZeneca ☐ Other ☐

If Other, please specify _____

Please provide date of: First dose D D / M M / Y Y Second dose D D / M M / Y Y

Second dose not yet given ☐

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 **Were there problems in this pregnancy?[2]*** Yes ☐ No ☐

If Yes, please specify _____

4.4 **Was the woman admitted to hospital?** Yes ☐ No ☐

If Yes, please give date of admission D D / M M / Y Y

If Yes, what was her oxygen saturation on admission ☐☐☐ **%** or tick if not measured? ☐

What was the primary reason for admission? *(please tick one)*

COVID-19 disease or symptoms ☐ Delivery ☐ Other ☐

If Other, please specify _____

Diagnosis of COVID-19

4.5 **Please indicate presenting symptoms and date of onset in the table below**

Symptom	Tick if Yes	If Yes, give date of onset
Fever	☐	D D / M M / Y Y
Cough	☐	D D / M M / Y Y
Sore throat	☐	D D / M M / Y Y
Headache	☐	D D / M M / Y Y
Tiredness/lethargy	☐	D D / M M / Y Y
Limb or joint pain	☐	D D / M M / Y Y
Diarrhoea	☐	D D / M M / Y Y
Breathlessness	☐	D D / M M / Y Y
Vomiting	☐	D D / M M / Y Y
Rhinorrhoea	☐	D D / M M / Y Y
Anosmia	☐	D D / M M / Y Y

4.6 Has virological testing for COVID-19 been carried out?

Yes - for symptoms ☐ Yes - routine screening ☐ No ☐

If Yes, did this confirm the diagnosis? Yes ☐ No ☐

If Yes, please specify

SARS-CoV-2 variant (state if not known) _____

Date of first positive test D D / M M / Y Y

Were there any subsequent positive tests? Yes ☐ No ☐

If Yes, please give date(s) of subsequent positive tests 1: D D / M M / Y Y

2: D D / M M / Y Y

If No, what was the final diagnosis? _____

4.7 Was this a clinical diagnosis only? Yes ☐ No ☐

4.8 Did the women have confirmed pneumonia on imaging? Yes ☐ No ☐

4.9 Was a potential source (contact) of COVID-19 infection identified? Yes ☐ No ☐

If Yes, was the source in the UK ☐ Abroad ☐

If Abroad, which country? _____

Therapy

4.10 Was this woman recruited to the RECOVERY trial? Yes ☐ No ☐

4.11 Were anti-viral drugs used? Yes ☐ No ☐

If Yes, please specify	First Agent	Second Agent
Agent used		
Date treatment started	D D / M M / Y Y	D D / M M / Y Y
Date treatment stopped	D D / M M / Y Y	D D / M M / Y Y
Dose		
Route		
Schedule *(e.g. bd)*		
Adverse effects		

4.12 Were other drugs used during pregnancy? Yes ☐ No ☐

If Yes, please specify _____

4.13 Were steroids given to enhance fetal lung maturation? Yes ☐ No ☐

If Yes, please specify

	First Agent	Second Agent
Agent used		
Date given	D D / M M / Y Y	D D / M M / Y Y
Dose		

4.14 Did the women require respiratory support for COVID-19 disease? Yes ☐ No ☐

If Yes, what was the maximal level of support required *(please tick one)*

O_2 via nasal prongs ☐ O_2 via mask ☐ O_2 via non-rebreathe mask ☐

CPAP ☐ Invasive ventilation ☐ ECMO ☐

If this women received O_2 via nasal prongs or mask, what was the maximum flow rate

☐☐ **litres/min**

If this women received ECMO, please indicate:

Date ECMO commenced D D / M M / Y Y

Name of ECMO centre _____

Was this woman delivered during her ECMO treatment? Yes ☐ No ☐

If Yes, please give reason for delivery _____

4.15 Were any of the following samples tested for SARS-COV-2 virus or antibody? *(tick all that apply)*

Sample type	Tested?	**If Yes,** what was the test type *e.g. PCR, IgG*?	**If Yes,** what was the test result?
Amniotic fluid	Yes ☐ No ☐		
Placenta	Yes ☐ No ☐		
Cord Blood	Yes ☐ No ☐		
High vaginal swab	Yes ☐ No ☐		
Faeces	Yes ☐ No ☐		
Other pregnancy tissue	Yes ☐ No ☐		

4.16 Did this women receive thromboprophylaxis or anticoagulation? Yes No

If Yes, please specify agent, dose and duration _____

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 D D / M M / Y Y

Was the pregnancy terminated due to a congenital malformation? Yes ☐ No ☐

If Yes, please specify _____

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

_____

If still undelivered, please complete section 6a and then go to section 7.
If the woman has delivered, please continue.

5.4 Was delivery induced? Yes ☐ No ☐

If Yes, please state indication _____

Was vaginal prostaglandin used? Yes ☐ No ☐

5.5 Did the woman labour? Yes ☐ No ☐

If Yes, please give date and time of onset of labour D D / M M / Y Y h h : m m (24hr)

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 ☐

5.7 Was delivery expedited due to COVID-19 disease? Yes ☐ No ☐

If Yes, what was the level of respiratory support she was receiving at the time of decision for delivery? *(please tick one)*

O_2 via nasal prongs ☐ O_2 via mask ☐ O_2 via non-rebreathe mask ☐

CPAP ☐ Invasive ventilation ☐ ECMO ☐

If this women received O_2 via nasal prongs or mask, what was the maximum flow rate

☐☐ **litres/min**

Section 6: Outcomes

Section 6a: Woman

6a.1 Was the woman admitted to Level 3 critical care? Yes ☐ No ☐

If Yes, please specify

Duration of stay ☐☐ days

Or Tick if woman is still in Level 3 critical 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 What was the woman's date of discharge after her admission for COVID-19? D D / M M / Y Y

6a.4 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.) _____

Section 6b: 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 D D / M M / Y Y h h : m m (24hr)

6b.2 Mode of delivery Spontaneous vaginal ☐ Ventouse or 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 ☐

If Yes, please specify

Duration of stay ☐☐ days

Or Tick if infant is still in neonatal unit ☐

Or Tick if infant was transferred to another hospital ☐

6b.8 **Did any other major infant complications occur?[7]*** Yes ☐ No ☐

If Yes, please specify _____

6b.9 **Was the infant diagnosed with COVID-19 infection?**

Yes - sample taken <12 hours ☐ Yes – sample taken >/=12 hours ☐ No ☐

6b.10 **Did the infant have a congenital anomaly?** Yes ☐ No ☐

If Yes, please specify _____

6b.11 **Did this infant die?** Yes ☐ No ☐

If Yes, please specify date of death D D / M M / Y Y

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.

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
Secondary infection e.g.pneumonia
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