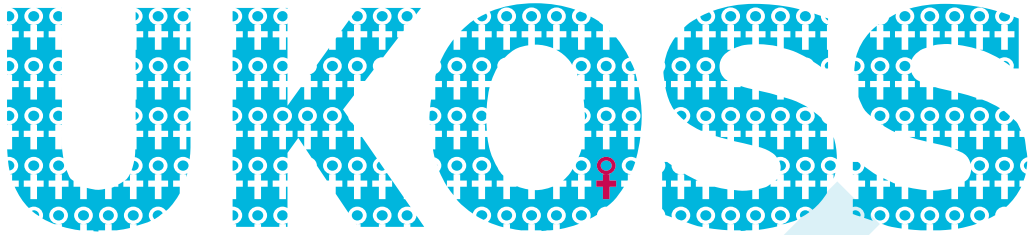


ID Number:



UK Obstetric Surveillance System

## Influenza Study XX/XX

Data Collection Form - CASE

**Please report all pregnant women admitted on or after 1st Xxxx XXXX  
and before 1st Xxxx XXXX**

### Case Definition:

Any woman admitted to hospital with confirmed pandemic influenza 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 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<sup>1\*</sup> (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?<sup>2\*</sup>

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?<sup>3\*</sup> Yes  No

If Yes, please specify \_\_\_\_\_

3.3 Has the woman been immunised against pandemic influenza? Yes  No

If Yes, please give:

Dates immunised Was this seasonal influenza vaccine or pandemic-type vaccine?  
/ /  Seasonal  Pandemic

/ /  Seasonal  Pandemic

/ /  Seasonal  Pandemic

/ /  Seasonal  Pandemic

If No, please state reasons for non-immunisation (tick all that apply) Not offered  Not available

Contraindicated  Safety concerns  Woman's preference  Not known

### Section 4: This Pregnancy

4.1 Final Estimated Date of Delivery (EDD)<sup>4\*</sup> / /

4.2 Was this pregnancy a multiple pregnancy? Yes  No

If Yes, specify number of fetuses

4.3 Were there problems in this pregnancy?<sup>2\*</sup> Yes  No

If Yes, please specify \_\_\_\_\_

4.4 Was the woman admitted to hospital? Yes  No

If Yes, please give date of admission / /

### Diagnosis of Pandemic Influenza

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	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Cough	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Sore throat	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Headache	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Tiredness/lethargy	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Limb or joint pain	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Diarrhoea	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Breathlessness	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Vomiting	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Rhinorrhoea	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Flu-like symptoms	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

\*For guidance please see back cover

**4.6 Has virological testing for influenza been carried out?**

Yes  No

If Yes, did this confirm the diagnosis?

Yes  No

If Yes, please specify

Type identified \_\_\_\_\_

Sample source \_\_\_\_\_

Date of first positive test

/   /

Were there any subsequent positive tests?

Yes  No

If Yes, please give date(s) of subsequent positive tests

1:   /   /

2:   /   /

If No, what was the final diagnosis? \_\_\_\_\_

**4.7 Was this a clinical diagnosis only?**

Yes  No

**Therapy**

**4.8 Were anti-viral drugs used for influenza infection?**

Yes  No

If Yes, please specify

**First Agent**

**Second Agent**

**Agent used** \_\_\_\_\_

**Date treatment started**

/   /

/   /

**Date treatment stopped**

/   /

/   /

**Dose** \_\_\_\_\_

**Route** \_\_\_\_\_

**Schedule (e.g. bd)** \_\_\_\_\_

**Adverse effects** \_\_\_\_\_

**4.9 Were other drugs used during pregnancy?**

Yes  No

If Yes, please specify \_\_\_\_\_

**4.10 Were steroids given to enhance fetal lung maturation?**

Yes  No

If Yes, please specify

**First Agent**

**Second Agent**

**Agent used** \_\_\_\_\_

**Date given**

/   /

/   /

**Dose** \_\_\_\_\_

**4.11 Was this woman managed with extracorporeal membrane oxygenation (ECMO)?**

Yes  No

If Yes, please indicate:

Date ECMO commenced

/   /

Name of ECMO centre \_\_\_\_\_

Was this woman delivered during her ECMO treatment?

Yes  No

If Yes, please give reason for delivery \_\_\_\_\_

\*For guidance please see back cover

## Section 5: Delivery

**5.1 Did this woman have a miscarriage?**

Yes  No

If Yes, please specify date

/   /

**5.2 Did this woman have a termination of pregnancy?**

Yes  No

If Yes, please specify date

/   /

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

/   /     :     
24hr

**5.6 Was delivery by caesarean section?**

Yes  No

If Yes, please state:

Grade of urgency<sup>5\*</sup>

Indication for caesarean section \_\_\_\_\_

Method of anaesthesia:

Regional

General anaesthetic

\*For guidance please see back cover

## 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?<sup>6\*</sup>**

Yes  No

If Yes, please specify \_\_\_\_\_

**6a.3 What was the woman's date of discharge after her admission for flu?**

/  /

**6a.4 Did the woman 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.) \_\_\_\_\_

### 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](http://www.npeu.ox.ac.uk/ukoss)

**6b.1 Date and time of delivery**

/  /   :  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, 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?<sup>7\*</sup>**

Yes  No

If Yes, please specify \_\_\_\_\_

\*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  
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





— UK Obstetric Surveillance System —

## Pandemic Influenza in Pregnancy

### Case ID:

Thank you for reporting the above case to UKOSS.

Now please make a note of the following details to keep in the UKOSS folder in case of future queries.

**Patient's name:** \_\_\_\_\_

**Patient's Hospital number:** \_\_\_\_\_

**Patient's year of birth:** \_\_\_\_\_

**EDD:** \_\_\_\_\_

**Case reported by:**

**Date reported:**

Please keep this sheet with these identifying details,  
do not send them to UKOSS.

Return the rest of the form to the address given on the front.