PREP CLINICIANS MANAGEMENT PLAN (CMP)

Hospital No..... **Name**..... **Gestational age** .....wks.....days

CURRENT SYMPTOMS					
Headache – generalised	Yes ☐	No☐	Visual disturbances	Yes ☐	No☐
Headache – localised	Yes ☐	No☐	Epigastric pain	Yes ☐	No☐
Nausea	Yes ☐	No☐	Vomiting	Yes ☐	No☐
Chest pain	Yes ☐	No☐	Breathlessness	Yes ☐	No☐
Fetal movements	Felt☐		Other symptoms	Yes ☐	No☐
	Not Felt ☐		*If yes, please specify:*		
	Reduced ☐		_____		

EXAMINATION				
Blood Pressure (Highest reading)	_____ / _____ mmHg			
Urine dipstick	None ☐	Trace ☐		
	1+☐	2+☐	3+☐	>4+☐
Exaggerated tendon reflexes	Yes ☐	No ☐		
Clonus	1+☐	2+☐	≥3+☐	None☐
Papilloedema	Yes ☐	No ☐	Not done ☐	
Pulse Oximetry (SaO_2)on air	.....%			

TREATMENT / MANAGEMENT:	Decision	If yes, give reason(s) – please list all that apply (see INDICATION codes)	INDICATION code
Administration of steroids	Yes ☐ No ☐		1. Severe hypertension
Start/increase dose/number of oral anti-hypertensives	Yes ☐ No ☐		2. Abnormal blood results
Start parenteral anti-hypertensives	Yes ☐ No ☐		3. Pathological/suspicious CTG
Admission to HDU	Yes ☐ No ☐		4. Likely to be a preterm birth
Start Magnesium Sulphate	Yes ☐ No ☐		5. Fetal compromise on scan
Plan for delivery	Yes ☐ No ☐		6. Symptoms
Manage as outpatient	Yes ☐ No ☐		7. Significant proteinuria
Manage as inpatient/In utero Transfer	Yes ☐ No ☐		8. Exaggerated reflexes/ clonus
			9. Other, please specify .....

Date ___/___/___ *Time* 00:00	*Signature* *PRINT NAME:*	*Your designation / grade*	*Bleep No.*

PREP CLINICIANS MANAGEMENT PLAN (CMP)

Hospital No..... **Name**..... **Gestational age** .....wks.....days

CURRENT SYMPTOMS					
Headache – generalised	Yes ☐	No☐	Visual disturbances	Yes ☐	No☐
Headache – localised	Yes ☐	No☐	Epigastric pain	Yes ☐	No☐
Nausea	Yes ☐	No☐	Vomiting	Yes ☐	No☐
Chest pain	Yes ☐	No☐	Breathlessness	Yes ☐	No☐
Fetal movements	Felt☐		Other symptoms	Yes ☐	No☐
	Not Felt ☐		*If yes, please specify:*		
	Reduced ☐		_____		

EXAMINATION				
Blood Pressure (Highest reading)	_____ / _____ mmHg			
Urine dipstick	None ☐	Trace ☐		
	1+☐	2+☐	3+☐	>4+☐
Exaggerated tendon reflexes	Yes ☐	No ☐		
Clonus	1+☐	2+☐	≥3+☐	None☐
Papilloedema	Yes ☐	No ☐	Not done ☐	
Pulse Oximetry (SaO_2)on air	.....%			

TREATMENT / MANAGEMENT:	Decision	If yes, give reason(s) – please list all that apply (see INDICATION codes)	INDICATION code
Administration of steroids	Yes ☐ No ☐		1. Severe hypertension
Start/increase dose/number of oral anti-hypertensives	Yes ☐ No ☐		2. Abnormal blood results
Start parenteral anti-hypertensives	Yes ☐ No ☐		3. Pathological/suspicious CTG
Admission to HDU	Yes ☐ No ☐		4. Likely to be preterm a birth
Start Magnesium Sulphate	Yes ☐ No ☐		5. Fetal compromise on scan
Plan for delivery	Yes ☐ No ☐		6. Symptoms
Manage as outpatient	Yes ☐ No ☐		7. Significant proteinuria
Manage as inpatient/In utero Transfer	Yes ☐ No ☐		8. Exaggerated reflexes/ clonus
			9. Other, please specify .....

Date ___/___/___ *Time* 00:00	*Signature* *PRINT NAME:*	*Your designation / grade*	*Bleep No.*

PREP clinicians management plan (CMP)_V3.0_1/MAY/2012

Participant UTIN

_ _ _ _/_ _ _ _

Development and validation of a **P**rediction model for **R**isk of complications in **E**arly onset **P**re-eclampsia

Data **C**ollection **F**orm

FORM A

Baseline

FORM B1
Clinical & Laboratory Assessment

DATE FORM FILLED DD /MMM /YYYY

Participant UTIN __ __ __/__ __ __

1. CLINICAL ASSESSMENT

Symptoms assessed Yes ☐ No ☐ *If yes, please specify below*

Date and time when symptoms assessed DD /MMM /YYYY HH:MM

1.1. Current symptoms

Headache – generalised	Yes ☐	No ☐	NK ☐	**Visual disturbances**	Yes ☐	No ☐	NK ☐
Headache – localised	Yes ☐	No ☐	NK ☐	**Epigastric pain**	Yes ☐	No ☐	NK ☐
Nausea	Yes ☐	No ☐	NK ☐	**Vomiting**	Yes ☐	No ☐	NK ☐
Chest pain	Yes ☐	No ☐	NK ☐	**Breathlessness**	Yes ☐	No ☐	NK ☐
Fetal movement	Felt ☐	Not Felt ☐	NK ☐ Reduced ☐	**Other symptoms** *If yes to Other symptoms, please specify*	Yes ☐	No ☐	NK ☐ _____

1.2. Examination

Blood Pressure *If multiple readings use the highest reading*	Systolic BP _____mmHg Diastolic BP _____mmHg		
Papilloedema	Yes ☐	No ☐	Not done ☐
Pulse Oximetry (SaO_2) on air	_____%		NK☐
Exaggerated tendon reflexes	Yes ☐	No ☐	NK ☐
Clonus	Yes ☐	No ☐	NK ☐
If yes, please select	1 beat ☐	2 beats ☐	≥ 3 beats ☐

2. LABORATORY ASSESSMENTS

2.1. Urine tests

Urine test done Yes ☐ No ☐ *If yes, please specify below*

Urine dipstick None ☐ Trace☐ 1+ ☐ 2+ ☐ 3+ ☐ ≥4+☐ **Date test performed** DD /MMM /YYYY

24h urine protein _____ g/24 hrs **Date sample taken** DD /MMM /YYYY

Protein Creatinine Ratio(PCR) _____ mg/mmol **Date sample taken** DD /MMM /YYYY

Albumin Creatinine Ratio(ACR) _____ mg/mmol **Date sample taken** DD /MMM /YYYY

2.2. Blood tests results - *Please provide units for those not specified*

Blood tests done Yes ☐ No ☐ *If yes, please specify* **Date sample taken** DD /MMM /YYYY

Haemoglobin	_____	**Serum bilirubin**	_____ µmol/l
White cell count	_____ x10⁹/l	**Alanine Transaminase**	_____ U/l
Platelet count	_____ x10⁹/l	**Aspartate Transaminase**	_____ U/l
Prothrombin time	_____ sec	**Serum albumin**	_____
Activated Plasma Thromboplastin Time	_____ sec	**Serum uric acid /Urate**	_____
Serum fibrinogen	_____ g/l	**Lactate dehydrogenase**	_____ U/l
Na	_____ mmol/l	**Serum urea**	_____
K	_____ mmol/l	**Serum creatinine**	_____ µmol/l
HCO3	_____ mmol/l	**Ca**	_____ mmol/l

After completing the form please sign below

Initials ____ ____ **Signature** _____

FORM B2
Ultrasound & cardiotocography findings

DATE FORM FILLED DD / MMM / YYYY

Participant UTIN __ __ __/__ __ __

1. ULTRASOUND & CARDIOTOCOGRAPHY FINDINGS

Estimated delivery date by scan DD / MMM / YYYY

If more than <u>two</u> fetuses, please copy this form and fill fields as required.
In case of singleton pregnancy, please cross out irrelevant section.

1.1. Details

Fetus No.		**Liquor volume**	Excess ☐	Normal ☐	Reduced ☐	NK ☐	**Date of scan** DD / MMM / YYYY
Umbilical artery Doppler End diastolic flow			Present ☐	Absent ☐	Reversed ☐	NK ☐	**Date of scan** DD / MMM / YYYY
Any other abnormal Doppler? (eg MCA, DV)			Yes☐ No☐	*If yes, please specify*			_____
Fetal weight on ultrasound growth chart	_____ g		**Gestational Age**	_____wks _____days			**Date of scan** DD / MMM / YYYY
Date of cardiotocography	DD / MMM / YYYY		**CTG findings**	Normal ☐	Suspicious ☐	Pathological ☐	NK ☐

1.2. Details

Fetus No.		**Liquor volume**	Excess ☐	Normal ☐	Reduced ☐	NK ☐	**Date of scan** DD / MMM / YYYY
Umbilical artery Doppler End diastolic flow			Present ☐	Absent ☐	Reversed ☐	NK ☐	**Date of scan** DD / MMM / YYYY
Any other abnormal Doppler? (eg MCA, DV)			Yes☐ No☐	*If yes, please specify*			_____
Fetal weight on ultrasound growth chart	_____ g		**Gestational Age**	_____wks _____days			**Date of scan** DD / MMM / YYYY
Date of cardiotocography	DD / MMM / YYYY		**CTG findings**	Normal ☐	Suspicious ☐	Pathological ☐	NK ☐

After completing the form please sign below

Initials ____ ____ **Signature** _____

FORM B3

CLINICAL MANAGEMENT PLAN

DATE FORM FILLED DD /MMM /YYYY

Participant UTIN __ __ __/__ __ __

CLINICIAN'S MANAGEMENT PLAN AT DIAGNOSIS (*from PREP CMP Sticker*)

For use when a previously suspected diagnosis of pre-eclampsia is confirmed for a patient before 34/40

Action	Decision Yes	Decision No	Reason(s)	INDICATION code
A. Administration of steroids	☐	☐	_____	1. Severe hypertension
B. Start/Increase the dose or number of oral anti-hypertensives	☐	☐	_____	2. Abnormal blood results
C. Start parenteral anti-hypertensives	☐	☐	_____	3. Pathological/suspicious CTG
D. Admission to HDU	☐	☐	_____	4. Likely to be a preterm birth
E. Start Magnesium Sulphate	☐	☐	_____	5. Fetal compromise on scan
F. Plan for delivery	☐	☐	_____	6. Symptoms
G. Manage as outpatient	☐	☐	_____	7. Significant proteinuria
H. Manage as inpatient/In utero transfer	☐	☐	_____	8. Exaggerated reflexes (or) clonus
				9. Other – please specify reason _____

After completing the form please sign below

Initials	___ ___	Signature	_____	Date of assessment	DD /MMM /YYYY

FORM C
Management Provided in Pregnancy and Delivery Outcomes

DATE FORM FILLED DD /MMM /YYYY

Participant UTIN __ __ __/__ __ __

1. MANAGEMENT PROVIDED IN PREGNANCY SINCE DIAGNOSIS UNTIL DISCHARGE

Please specify only once

Steroids	Yes ☐ No ☐	***Start date and time***	DD /MMM /YYYY HH:MM	
Magnesium Sulphate (MgSO4)	Yes ☐ No ☐	***Start date and time***	DD /MMM /YYYY HH:MM	
Transferred out for care	Yes ☐ No ☐	**Date**	DD /MMM /YYYY	

*If **yes**, please complete forms B1, B2 and D with data from the unit transferred*

In case of multiple data please fill more than one form

Parenteral antihypertensive Yes ☐ No ☐ *If **yes**, specify below*

		Start date and time	***End date and time***	***On-going***
Labetalol	☐	DD /MMM /YYYY HH:MM	DD /MMM /YYYY HH:MM	☐
Hydralazine	☐	DD /MMM /YYYY HH:MM	DD /MMM /YYYY HH:MM	☐

	Date and time
Infusion of any third parenteral antihypertensive Yes☐ No☐	DD /MMM /YYYY HH:MM

Oral antihypertensive Yes ☐ No ☐ *If **yes**, specify below*

	Max daily dose		***Start date***	***End date***	***On-going***	***Dose increased in pregnancy***
Labetalol	☐	***mg***	DD /MMM /YYYY	DD /MMM /YYYY	☐	Yes ☐ No ☐
Nifedipine	☐	***mg***	DD /MMM /YYYY	DD /MMM /YYYY	☐	Yes ☐ No ☐
Methyldopa	☐	***mg***	DD /MMM /YYYY	DD /MMM /YYYY	☐	Yes ☐ No ☐

Admission to HDU	Yes ☐ No ☐	***Total days spent***	_____
		Date and time of 1st admission	DD /MMM /YYYY HH:MM

FORM D
Maternal and Neonatal Outcomes

DATE FORM FILLED DD / MMM / YYYY

Participant UTIN __ __ __/__ __ __

1. MATERNAL OUTCOMES	Presence		Date and Time of outcome occurrence	
1.1. Mortality				
Maternal death	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
1.2. Central nervous system				
Eclamptic seizures	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
GCS (Glasgow Coma Scale) score<13	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
Stroke or RIND (Reversible Ischemic Neurological Deficit)	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
Cortical blindness	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
Retinal detachment	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
Posterior reversible encephalopathy	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
Bell's palsy	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
1.3. Hepatic				
Hepatic dysfunction	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
Subcapsular haematoma	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
Hepatic capsule rupture	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
1.4. Cardiorespiratory				
Need for positive inotrope support	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
Myocardial ischaemia or infarction	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
At least 50% FIO2 for greater than 1 hour	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
Intubation	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
Pulmonary oedema	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
1.5. Renal				
Acute renal insufficiency (creatinine >200uM)	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
Dialysis	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
1.6. Haematological				
Transfusion of any blood product	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
Abruption	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
Postpartum haemorrhage (PPH)	Yes ☐	No ☐	DD / MMM / YYYY	HH:MM
*If yes to **PPH occurrence**, please select:*		*Type*	Traumatic ☐	Atonic ☐
		Blood loss	1.0-1.5L ☐	>1.5L ☐
Date and time of mother's discharge	DD / MMM / YYYY HH:MM			