PREGNANCY MODULE (Form 1): complete on admission/enrolment

Is Subject Pregnant or recently delivered within 21 days from onset of symptoms?
☐Yes ☐No ☐Unknown

If "yes" Answer the following

Q1. STATUS UPON ADMISSION	
Pregnant not in labour	☐
Pregnant in labour	☐
Postpartum [days]*	☐ [days] Breastfeeding? ☐ YES ☐ NO
Post-abortion, miscarriage	☐
Number of foetuses	☐Singleton ☐Twin ☐Triplet ☐Other [number] ☐ Unknown
Best estimate of gestational age in completed weeks	[_W_][_W_] weeks

* This form does not need to be completed if symptoms of COVID-19 started more than 21 days post-partum

Q2. ABORTION OR MISCARRIAGE prior to admission	
Date of induced abortion or spontaneous abortion/miscarriage? Were symptoms of COVID-19 disease present at the time?	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] ☐ YES ☐ NO ☐ UNKNOWN

Q3. OBSTETRIC HISTORY
Number of previous pregnancies beyond 22 weeks gestation [number]

Please tick any which apply to previous deliveries:	
Preterm birth (<37 weeks' gestation)	☐ YES ☐ NO ☐ UNKNOWN
Congenital anomaly	☐ YES ☐ NO ☐ UNKNOWN
Stillborn	☐ YES ☐ NO ☐ UNKNOWN
Neonatal death (0-6 days)	☐ YES (day:) ☐ NO ☐ UNKNOWN
Weight < 2.5kg	☐ YES ☐ NO ☐ UNKNOWN
Weight > 4.5kg	☐ YES ☐ NO ☐ UNKNOWN

Q4. ALCOHOL, DRUGS– RISK FACTORS	
Alcohol consumption during this pregnancy	☐ YES ☐ NO ☐ UNKNOWN
Illicit and recreational drug use during this pregnancy	☐ YES ☐ NO ☐ UNKNOWN

Q5. MEDICATIONS DURING THIS PREGNANCY (Prior to onset of current illness episode)		
Fever or pain treatment	**Acetaminophen/paracetamol**	☐YES ☐NO ☐UNKNOWN
	NSAID/s	☐YES ☐NO ☐UNKNOWN
	Other/s (specify): [ ]	
Anticonvulsants	☐YES ☐NO ☐UNKNOWN **If yes, specify generic name: [ ]**	
Anti-nausea	☐YES ☐NO ☐UNKNOWN **If yes, specify generic name: [ ]**	
Prenatal vitamins and micronutrients	☐Yes ☐No ☐Unknown **If yes, specify (e.g. folic acid): [ ]**	
Antivirals	☐YES ☐NO ☐UNKNOWN **If yes, specify generic name: [ ]**	
Antibiotics	☐YES ☐NO ☐UNKNOWN **If yes, specify generic name: [ ]**	

Q6. ADMISSION SIGNS AND SYMPTOMS	
Vaginal watery discharge	☐ YES ☐ NO ☐ UNKNOWN
Vaginal bleeding	☐ YES ☐ NO ☐ UNKNOWN
Headaches	☐ YES ☐ NO ☐ UNKNOWN
Vision changes	☐ YES ☐ NO ☐ UNKNOWN
Right upper quadrant (abdominal) pain	☐ YES ☐ NO ☐ UNKNOWN
Decreased or no fetal movement	☐ YES ☐ NO ☐ UNKNOWN
Uterine contractions	☐ YES ☐ NO ☐ UNKNOWN

Q7. FETAL HEART RATE (first available data at presentation/admission)	
Fetal heart rate	**(FHR):** [_ _][_ _][_ _] beats/min

PREGNANCY MODULE (Form 2): follow-up

(For Daily Assessment, frequency of completion determined by available resources)

Date of follow up [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]

Q1. FETAL HEART RATE (Follow up)	
Fetal heart rate (record most abnormal value between 00:00 to 24:00)	**(FHR):** [_ _][_ _][_ _] beats/min

Q2. TREATMENT DURING HOSPITALISATION At ANY time during hospitalisation, did the patient receive/undergo:	
Tocolysis	☐ YES ☐ NO ☐ UNKNOWN
Induction of labour	☐ YES ☐ NO ☐ UNKNOWN
Blood transfusion	☐ YES ☐ NO ☐ UNKNOWN

PREGNANCY MODULE (Form 3): complete at discharge/death

Q1. DELIVERY, PREGNANCY AND MATERNAL OUTCOMES		
Delivery during admission	☐Yes ☐ No **If yes, date:** [_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_]	
If delivered during admission, specify mode of delivery:	☐ Vaginal delivery ☐ Caesarean section	
Onset of labour	☐ Spontaneous ☐ Induced ☐ Cesarean section before labour ☐ Unknown	
Amniotic fluid at delivery	☐ Clear ☐ Meconium stained ☐ Unknown	
Other maternal outcomes/pregnancy complications	Gestational diabetes Gestational hypertension Anemia (Hb < 11 g/dL) Hyperemesis Intrauterine growth restriction Placental previa/accreta/percreta Bacterial infection prior to hospital visit Pre eclampsia/eclampsia Placental abruption Preterm contractions Preterm labor Preterm rupture of membranes Early or mid term miscarriage Haemorrhage **If haemorrhage, which type:** Embolic disease Anesthestic complication	☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN ☐ Antepartum/intrapartum ☐ Postpartum hemorrhage ☐ Abortion-related ☐ YES ☐ NO ☐ UNKNOWN ☐ YES ☐ NO ☐ UNKNOWN

Q2. PREGNANCY STATUS AT DISCHARGE	
Pregnancy outcome	☐Undelivered ☐Spontaneous abortion ☐ Induced abortion ☐Missed abortion ☐Macerated stillbirth ☐Fresh stillbirth ☐Livebirth
Maternal death **If yes, what was the primary cause of death?**	☐Yes ☐ No ☐ Severe acute respiratory infection ☐Obstetric hemorrhage ☐Hypertensive disorder ☐Obstetric related infection ☐Abortion/ectopic pregnancy ☐Other direct cause ☐Indirect cause ☐Unknown

	Q3. Sample Collection			
Any sampling conducted? If so, please describe the test and the results	☐ Amniotic fluid	[_test description__]	[_date of collection__]	[_____result_____]
	☐ Placenta	[_test description__]	[_date of collection__]	[_____result_____]
	☐ Cord blood	[_test description__]	[_date of collection__]	[_____result_____]
	☐ Vaginal swab	[_test description__]	[_date of collection__]	[_____result_____]
	☐ Faeces/rectal swab	[_test description__]	[_date of collection__]	[_____result_____]
	☐ Pregnancy tissue in the case of fetal demise / induced abortion	[_test description__]	[_date of collection__]	[_____result_____]
	☐ Breastmilk	[_test description__]	[_date of collection__]	[_____result_____]

Q4. NEONATAL OUTCOMES	
Date of birth [DD/MM/YYYY] Time of birth [e.g. 14:21]	[_D_][_D_]/[_M_][_M_]/[_2_][_0_][_Y_][_Y_] [____:____]
Participant ID of the mother:	[___][___][___][___][___]-- [___][___][___][___] **-** [__Single digit Baby ID_]* ***complete one form per neonate**
COVID-19 lab test of foetus or neonate	☐ Performed ☐ Not performed ☐ Unknown If yes: [_sample collected__] [_test description__] [_date of collection__] [_____result_____]
Apgar score at 5 minutes	Score: [___][___]
Gestational age	Weeks: [___][___] Days: [_____]
Birth weight	Grams: [___][___][___][___]
Respiratory distress syndrome	☐ YES ☐ NO ☐ UNKNOWN
Neonatal outcome	☐ Discharged healthy ☐ Discharged with complications/sequelae Details: [_____] ☐ Clinical referral to specialist ward /other hospital Details: [_____] ☐ Death Date of death: [_D_][_D_]/[_M_][_M_]/[_Y_][_Y_] ☐ Unknown
If neonate died, primary cause of death	☐ Preterm/low birth weight ☐ Birth asphyxia ☐ Infection ☐ Birth trauma ☐ Congenital/birth defects ☐ Other ☐ Unknown
Any congenital anomalies	☐ Neural tube defects ☐ Microcephaly ☐ Congenital malformations of ear ☐ Congenital heart defects ☐ Orofacial clefts ☐ Congenital malformations of digestive system ☐ Congenital malformations of genital organs ☐ Abdominal wall defects ☐ Chromosomal abnormalities ☐ Reduction defects of upper and lower limbs ☐ Talipes equinovarus/clubfoot