Imperial College London

PAN-COVID

Cardiff University Centre for Trials Research
Prifysgol Caerdydd Canolfan Ymchwil Treialon

Completed by:	Date of Completion:	Participant Identification Number:
PRINT NAME	DD / MM / YYYY	To be completed once registered on database

Data Collection Form

Please note we do not expect sites to complete this form in addition to entering data onto the registry. Please use this form if you cannot access the registry.
Please notify pan-covid@cardiff.ac.uk if you have completed data collection forms. We will then provide instruction on how to send over securely.

CONSENT

Has the participant provided verbal informed consent (tick one option only)? Yes ☐ No ☐

If no, what is the reason for no participant consent (tick one option only)?

Emergency consent, participant lacked capacity ☐

Emergency consent, provided by representative of participant ☐

Date the participant consented to participate in the study? DD / MM / YYYY

PARTICIPANT DETAILS

What is the participant's date of birth? DD / MM / YYYY

What is the participant's hospital number (for UK sites only, e.g. NHS or CHI)? XXXXXXXXXX

Does the participant have an expected date of delivery based on ultrasound (tick one option only)? Yes ☐ No ☐

If yes, please provide the expected date of delivery based on ultrasound: DD / MM / YYYY

If no, please provide the date of participant's last menstrual period: DD / MM / YYYY

Data Collection Form

PARTICIPANT DETAILS

What is the participant's BMI?

XX.XX kg/m^2

When was the BMI measurement taken (tick one option only)?

At booking ☐ Pre-pregnancy ☐

Does the participant currently smoke cigarettes or tobacco (tick one option only)?

Yes participant smokes ☐ No participant has never smoked ☐

No participant used to smoke but stopped before this pregnancy ☐ No participant stopped after they knew they were pregnant ☐

What is the participant's ethnicity (tick one option only)?

European / North American ☐ Middle East ☐

North Africa ☐ Africa South of Sahara, Caribbean ☐

Indian Subcontinent ☐ SE Asia ☐

South / Middle America ☐ Other ☐

COVID-19 DIAGNOSIS

Please describe the status of participant's COVID-19 diagnosis (tick one option only)?

Suspected ☐ Positive SARS-COV-2 test ☐ Negative SARS-COV-2 test ☐

Please describe the participant's symptoms using the list provided (tick all that apply):

Fever ☐ New, persistent cough ☐ Anosmia ☐ Myalgia ☐

Diarrhoea ☐ Shortness of breath ☐ Fatigue ☐ Loss of appetite ☐

Abdominal pain ☐ Chest pain ☐ Delirium ☐ Hoarse voice ☐

Data Collection Form

COVID-19 DIAGNOSIS

Date of SARS-COV-2 test or suspected COVID-19 diagnosis? DD / MM / YYYY

Has the participant had a chest scan or X ray (tick one option only)? Yes ☐ No ☐

If yes, was the scan / X ray appearance consistent with COVID-19 (tick one option only)? Yes ☐ No ☐

MEDICAL HISTORY

Please specify any medication the participant has taken during their pregnancy (tick all that apply):

- Aspirin ☐
- Progesterone ☐
- Immunosuppression ☐
- Any pregnancy vitamins ☐
- Low molecular weight heparin ☐
- Other ☐
- None ☐

If selected <u>other</u> to the above, please specify in the text box below what other medication the participant has taken during pregnancy?

Does the participant have any of the co-morbidities listed below (tick all that apply)?

- Chronic Hypertension ☐
- Pregnancy-induced Hypertension ☐
- Respiratory Disease ☐
- Cardiovascular Disease ☐
- Renal Disease ☐
- Autoimmune Disease ☐
- Pre-existing Diabetes ☐
- Gestational Diabetes ☐
- Other ☐
- None ☐

Data Collection Form

GRAVIDITY

Has the participant had any previous term (>37 weeks) pregnancies (tick one option only)?

Yes ☐ No ☐

If yes, please specify in the text box below, the outcome of each pregnancy (livebirth / neonatal death) and the birthweight (in grams):

For example:
Pregnancy 1, livebirth, 3000 grams
Pregnancy 2, neonatal death, 3700 grams

Has the participant had any previous pre-term pregnancies which ended between 23 and 36+6 weeks (tick one option only)?

Yes ☐ No ☐

If yes, please specify in the text box below, the outcome of each pregnancy (livebirth / neonatal death), how many weeks the participant was and the birthweight (in grams):

For example:
Pregnancy 1, livebirth, 35 weeks, 2500 grams
Pregnancy 2, neonatal death, 27 weeks, 1600 grams

Has the participant had any previous pregnancies which ended before 23 weeks (tick one option only)?

Yes ☐ No ☐

If yes, please specify in the text box below, the outcome of each pregnancy (miscarriage / termination) and how many weeks the participant was:

For example:
Pregnancy 1, termination, 8 weeks
Pregnancy 2, miscarriage, 20 weeks

Data Collection Form

COVID-19 PREGNANCY DETAILS

Please provide the number of fetuses the participant is carrying? X

Does the participant have pre-eclampsia (tick one option only)? Yes ☐ No ☐

Does the participant have eclampsia (tick one option only)? Yes ☐ No ☐

Does the participant have fetal growth restriction (tick one option only)? Yes ☐ No ☐

If yes, please describe the fetal growth restriction using the list provided (tick all that apply):

- Abdominal circumference or estimated fetal weight < 3rd centile ☐
- Umbilical artery or uterine artery PI > 95th centile ☐
- Abdominal circumference or estimated fetal weight reduced from 20/40 scan and crossed 50 centiles ☐
- Cerebro-umbilical ratio < 5th centile ☐

Please specify if the participant's fetus has any structural malformation(s) present on ultrasound (tick all that apply)?

- Head ☐
- Brain ☐
- Central Nervous System ☐
- Heart ☐
- Limb ☐
- Gastroenteritis ☐
- Urinary ☐
- Genital ☐
- None ☐

If applicable, does the participant's 2nd, 3rd, 4th &/or 5th fetus have any structural malformation(s) present on ultrasound? Please indicate which fetus in the text box provided:

2nd fetus -
3rd fetus -
4th fetus -
5th fetus -

Data Collection Form

COVID-19 DELIVERY DETAILS

Date of the participant's delivery? DD / MM / YYYY

What was the mode of the participant's delivery (tick one option only)?

Vaginal ☐ Caesarean ☐

If caesarean delivery, was it…(tick one option only)?

Planned ☐ Emergency ☐

If caesarean, what was the indication for delivery (tick one option only)?

Maternal Hypoxia ☐ Fetal compromise ☐ Other ☐

If <u>other</u>, please describe the indication for delivery below:

Was the participant's labour induced (tick one option only)?

Yes ☐ No ☐

What was the outcome of delivery (tick one option only)?

Livebirth ☐ Miscarriage ☐ Intra-uterine death, stillbirth (>22+6 weeks gestation) ☐

If yes to miscarriage, did the participant have a previous ultrasound scan (tick one option only)?

Yes ☐ No ☐

If yes, please use the list provided to describe the diagnosis at the scan (tick one option only):

Viable intra-uterine pregnancy ☐ Pregnancy unknown viability ☐ Pregnancy unknown location ☐

If the participant had a <u>livebirth</u>, please provide the number of babies delivered: X

Please specify if the participant's baby had any congenital abnormalities present at delivery (tick all that apply):

Head ☐ Brain ☐ Central Nervous System ☐ Heart ☐

Limb ☐ Gastroenteritis ☐ Urinary ☐ Genital ☐

None ☐

Data Collection Form

COVID-19 DELIVERY DETAILS

If applicable, please specify in the text box provided, if the participant's 2nd, 3rd, 4th &/or 5th baby had any congenital abnormalities present at delivery?

2nd baby -
3rd baby -
4th baby -
5th baby -

Please provide the birthweight of the baby or fetus (in grams): XXXX grams

If applicable, please provide the birthweight of the 2nd, 3rd, 4th &/or 5th baby or fetus (in grams) below:

2nd baby or fetus - XXXX grams
3rd baby or fetus - XXXX grams
4th baby or fetus - XXXX grams
5th baby or fetus – XXXX grams

Did COVID-19 lead to the participant requiring any of the following (tick one option only)?

Non-invasive ventilation ☐ Intubation and ventilation ☐ No ☐

If so, please provide the date when ventilation commenced: DD / MM / YYYY

If so, please provide the date when ventilation stopped: DD / MM / YYYY

Did the participant die (tick one option only)? Yes ☐ No ☐

If yes, please provide the date of participant's death: DD / MM / YYYY

If yes, please provide the presumed reason for the participant's death (tick one option only):

COVID-19 ☐ Pregnancy related ☐ Other ☐

Data Collection Form

BABY OUTCOMES

Please provide the baby's hospital number (for UK sites only, e.g. NHS or CHI): XXXXXXXXXX

If applicable, please provide the hospital number of the 2nd, 3rd, 4th &/or 5th baby in the text box below (for UK sites only e.g. NHS or CHI):

2nd baby -
3rd baby -
4th baby -
5th baby -

Please provide the gender of the participant's baby (tick one option only): Male ☐ Female ☐

If applicable, please provide the gender of the participant's 2nd, 3rd, 4th &/or 5th baby in the text box below:

2nd baby -
3rd baby -
4th baby -
5th baby -

What was the APGAR score at 5 minutes? X

If applicable, please write the APGAR score of the 2nd, 3rd, 4th &/or 5th baby at 5 minutes in the text box below:

2nd baby -
3rd baby -
4th baby -
5th baby -

Was the baby(s) separated from the participant immediately after delivery (tick one option only)? Yes ☐ No ☐

If yes, how many days were they separated? X days

Has the baby(s) received breastmilk from the participant (tick one option only)? Yes ☐ No ☐

Has the baby been tested for SARS-COV-2 (tick one option only) ? Yes ☐ No ☐

If yes, was the test positive for SARS-COV-2 (tick one option only)? Yes ☐ No ☐

Data Collection Form

BABY OUTCOMES

Please provide the date of baby's SARS-COV-2 test: DD / MM / YYYY

Please specify the type of sample taken to test for SARS-COV-2 (tick one option only):

Nasopharyngeal swab ☐ Cord blood ☐ Placenta ☐

Amniotic fluid ☐ Other ☐

Please provide the number of samples taken to test for SARS-COV-2: X

Please write in the text box provided, if the participant's 2nd, 3rd, 4th and/or 5th baby was tested for SARS-COV-2, indicating which baby, the outcome and date of test:

2nd baby -
3rd baby -
4th baby -
5th baby -

Please provide the date the participant's baby(s) was discharged from hospital: DD / MM / YYYY

Did the participant's baby experience any complications (tick one option only)? Yes ☐ No ☐

If yes, please specify the complications using the list provided (tick all that apply):

Transient tachypnea of newborn ☐ Respiratory distress syndrome ☐

Pneumonia ☐ None ☐

If yes, please specify the date of above diagnosis: DD / MM / YYYY

Data Collection Form

BABY OUTCOMES

If applicable, did the participant's 2nd, 3rd, 4th &/or 5th baby experience any complications (tick one option only)? Yes ☐ No ☐

If yes, please write in the text box below indicating which baby and the complications experienced:

2nd baby -
3rd baby -
4th baby -
5th baby -

Did the participant's baby die (tick one option only)? Yes ☐ No ☐

If yes, what was the date of baby's death? DD / MM / YYYY

If yes, what was the suspected cause of the baby's death?

If applicable, did the participant's 2nd, 3rd, 4th &/or 5th baby die (tick one option only)? Yes ☐ No ☐

If yes, please write in the text box below indicating which baby, the date of death and the suspected cause of death:

2nd baby -
3rd baby -
4th baby -
5th baby -

Data Collection Form

RE-ADMISSION

Was the participant's baby re-admitted to hospital at any point between date of delivery and 28 days old (tick one option only)?

Yes ☐ No ☐

If yes, what was the date of re-admission?

DD / MM / YYYY

If yes, what was the date the baby was discharged?

DD / MM / YYYY

If applicable, was the participant's 2nd, 3rd, 4th &/or 5th baby re-admitted to hospital at any point between date of delivery and 28 days old (tick one option only)?

Yes ☐ No ☐

If yes, please write in the text box below indicating which baby and the dates of re-admission and discharge:

2nd baby -
3rd baby -
4th baby -
5th baby -