MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

Case number:

PREGNANCY REPORT FORM

Sponsor: Médecins Sans Frontières	**Protocol/Program n°:**	**Site n° (for studies) or country:**
Initial report: ☒	**Follow-up report:** ☒	**Date of report:** ____ / _____ / _____ (dd/Mmm/yyyy)

Patient information (mother)

Patient n°: [Father ☐ Mother ☐]	Mother initials:	Mother date of birth: ____ / _____ / _____ (*dd/Mmm/yyyy*)	Mother height: ..... cm	Mother weight: ..... kg

Relevant drug(s) exposure before/during pregnancy

Drug name (INN)	.....	.....	.....	.....	.....	.....	.....
Daily dose & route							
Batch number							
Treatment start date (*dd/Mmm/yyyy*)	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____
Treatment stop date (*dd/Mmm/yyyy*)	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____
Drug taken by	**Father ☐ / Mother ☐**	**Father ☐ / Mother ☐**	**Father ☐ / Mother ☐**	**Father ☐ / Mother ☐**	**Father ☐ / Mother ☐**	**Father ☐ / Mother ☐**	**Father ☐ / Mother ☐**
Action taken in response to the pregnancy							
Dosage maintained	☐	☐	☐	☐	☐	☐	☐
Dose reduced	☐	☐	☐	☐	☐	☐	☐
New daily dose							
On (*dd/Mmm/yyyy*)	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____
Drug permanently withdrawn	☐	☐	☐	☐	☐	☐	☐
On (*dd/Mmm/yyyy*)	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____
Drug interrupted	☐	☐	☐	☐	☐	☐	☐
From (*dd/Mmm/yyyy*)	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____
To (*dd/Mmm/yyyy*)	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____	___ / ____ / _____
Not applicable	☐	☐	☐	☐	☐	☐	☐

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Pregnancy information			
Date of 1st day of last menstrual period	____ / _____ / _____ (*dd/Mmm/yyyy*)	**Estimated date of delivery**	____ / _____ / _____(*dd/Mmm/yyyy*)
Pregnancy test	☐ **Positive urine test** **Date**: ____ / _____ / _____ (*dd/Mmm/yyyy*)	☐ **Positive blood test** **Date**: ____ / _____ / _____ (*dd/Mmm/yyyy*)	☐ **Positive ultrasound** **Date:** ____ / _____ / _____ (*dd/Mmm/yyyy*)

Pregnancy outcome	
1. Did the patient experience any complication during pregnancy?	☐ **Yes. Specify**:
	☐ **No**
2. Did the patient give birth to (a) live infant(s)?	☐ **Yes. Date of delivery** (*dd/Mmm/yyyy*): ____ / _____ / _____
	☐ **No. Specify reason:**
3. Was the infant normal at birth?	☐ **Yes**
	☐ **No. Specify abnormality and reason:**
Additional comment on pregnancy/delivery	

Infant(s) information

Infant number	Infant sex	Infant length *(cm)*	Infant weight *(g)*	APGAR score	Exposure during breastfeeding	Comment
1	F ☐ M ☐				Yes ☐ No ☐	
2	F ☐ M ☐				Yes ☐ No ☐	
3	F ☐ M ☐				Yes ☐ No ☐	

Relevant medical history *(with focus on relevant prior gynaecological/obstetric history)*	

Reporter

Name of reporter:	**Role in trial/program:**	**Date of awareness:**	**Address:**	**Date and signature:**
		____ / _____ / _____	**Email:** **Phone:**	____ / _____ / _____