Swine Influenza Case Report: Addendum for Pregnant Cases

For Pregnant (non-hospitalized) cases, please complete this form in addition to the standard "Swine Influenza Case Report Form"

For Pregnant (hospitalized) cases, please also complete the "Clinical Description of Hospitalized Cases"

FAX to: 404-248-4094 or email to casereportforms@cdc.gov

State EPI ID # (epidemiology ID) _____ **CDC EPI ID #** _____

State lab specimen ID #1 _____ **CDC lab specimen ID #1** _____

State lab specimen ID #2 _____ **CDC lab specimen ID #2** _____

CDC (lab) unique ID # _____

Gravidity: _____ Parity: _____

Estimated Date of Delivery (EDC)? (mm/dd/yy): ___/____/____

Prenatal care: □Yes □No Initiated _____ weeks gestation?

Prenatal testing:

Any infection/STD diagnosed (includes syphilis, GC, HIV, Chlamydia, hepatitis)?
□Yes □ No Please specify (if yes): _____

Any birth defects identified prenatally? □Yes □ No
Please specify (if yes): _____

Please list any complications during pregnancy including:

□ Gestational diabetes
□ Pre-eclampsia/ pregnancy-induced hypertension
□ Preterm labor
□ Bleeding – If yes, specify diagnosis (i.e. source/cause of bleeding) and estimated gestational age at onset: _____

□Other (please specify): _____

Medications used during pregnancy

Fever treatment for influenza-like illness during pregnancy:

Acetominophen? □Yes □ No
NSAID? □Yes □ No

Antibiotics during pregnancy? □Yes □ No
If yes, please specify name of antibiotic, condition treated, treatment dates:

Other medications (please specify): _____

Outcome, Labor, and Delivery
Date of delivery (mm/dd/yy): ___/____/____
Estimated gestational age at delivery/termination: _____(weeks)

Intrapartum Complications:
- □ Hemorrhage
- □ Chorioamnionitis
- □ Other (please specify): _____

Length of labor____hours

Type of delivery
- □ Spontaneous abortion
- □ Therapeutic abortion
- □ Spontaneous vaginal delivery
- □ Vacuum-assisted vaginal delivery
- □ Forceps-assisted vaginal delivery
- □ Cesarean Delivery
  - Indication for C-section: _____

Postpartum complications (including postpartum hemorrhage): □Yes □ No
If yes, specify_____

Was patient febrile during labor and delivery or within 48 hours of delivery?
□Yes □ No

What was diagnosis and how was this treated? _____

Infant outcome (if post-partum)
Birth weight in grams_____
Apgar scores: _____ 1 minute _____ 5 minute

Admitted to NICU? □Yes □ No If yes, Number of days in NICU? _____

Other complications of the newborn during hospitalization (please describe, including any need for resuscitation, signs/symptoms of illness, sepsis, etc.?)

Date of discharge from hospital (mm/dd/yy):____/____/____ or death ____/___/_____

Any birth defects noted at birth?: □Yes □ No
If yes, please describe: _____

Contact information for Attending Physician
Name: _____
Phone: _____