Maternal Referral/Admission

Study Subject Number 0 1 – 0 0 0 1 **Visit Date** D D – M M – Y Y

Study Antenatal Clinic Code **Date of Birth** D D – M M – Y Y

Antenatal Record Number

Section 1: Pregnancy status

1. Is this a referral to another level of outpatient care or admission to hospital? (please cross one box only)

Referral ☐

Admission ☐

2. Which department/unit/service has she been referred or admitted to? (please cross one box only)

Gynaecology ☐ Surgery ☐
Obstetric/High-risk clinic ☐ Nutritional ☐
Urology/Nephrology ☐ Internal medicine ☐
Psychiatry ☐ Other ☐
Physiotherapy ☐

If she has been referred or admitted for a nutritional problem, please indicate the diagnosis (please cross all the boxes that are applicable)

3. Gestational diabetes ☐
4. Overweight ☐
5. Underweight ☐
6. Anaemia ☐
7. Food allergy ☐
8. Heartburn ☐
9. Malabsorption syndrome ☐
10. Specific dietary requirement ☐

Section 2: Lab information (If requested during admission/referral)

11. Proteinuria (by dipstick). Cross one box only

0 ☐ + ☐ ++ ☐
+++ ☐ ++++ ☐ no urine test performed at this referral/admission ☐

and/or actual result (from urine sample) received from laboratory. ☐☐☐ mg/dl

12. Urine culture (please cross one box only)

Positive ☐
Negative ☐
No urine culture available ☐

13. If positive was antibiotic treatment given? yes ☐ no ☐

14. Lowest haemoglobin level (if measured during admission) ☐☐.☐ g/dl

Section 3: Final clinical diagnosis for this admission or referral

Please provide the main diagnosis by referring to the medical records

15. Cardiac disease yes ☐ no ☐
16. Chronic respiratory disease (including chronic asthma) yes ☐ no ☐
17. Malaria yes ☐ no ☐
18. Mental illness e.g. depression yes ☐ no ☐
19. Epilepsy yes ☐ no ☐
20. Thyroid disease or any other endocrinological condition yes ☐ no ☐
21. Lower urinary tract infection requiring antibiotic treatment yes ☐ no ☐
22. Pyelonephritis yes ☐ no ☐
23. Respiratory tract infection requiring antibiotic/antiviral treatment yes ☐ no ☐
24. Any other infection requiring antibiotic/antiviral treatment yes ☐ no ☐
25. HIV or AIDS yes ☐ no ☐
26. Any type of malignancy/cancer (if yes, please complete an **adverse event form**) yes ☐ no ☐
27. Any sexually transmitted infection yes ☐ no ☐
28. Any other medical/surgical condition requiring treatment or surgery (if yes, please complete an **adverse event form**) yes ☐ no ☐

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Section 4: Pregnancy-related diagnosis for this admission or referral

Please provide the main diagnosis by referring to the medical records

29	Gestational diabetes	yes / no	38.	Prelabour rupture of membranes (PROM) or Preterm Labour without delivery	yes / no
30.	Vaginal bleeding	yes / no	39.	Preterm Labour or PROM and Delivery (if yes please complete the **pregnancy and delivery form**)	yes / no
31.	Miscarriage (please complete the **pregnancy and delivery form**)	yes / no	40.	Fetal death (if yes please complete the **pregnancy and delivery form**)	yes / no
32.	Pregnancy induced hypertension	yes / no	41.	Fetal distress	yes / no
33.	Preeclampsia	yes / no	42.	Suspected impaired fetal growth or small for gestational age	yes / no
34.	Severe Preeclampsia	yes / no	43.	Pelvic mass	yes / no
35.	Eclampsia/HELLP syndrome	yes / no	44.	Severe vomiting requiring hospitalisation	yes / no
36.	Multiple pregnancy	yes / no	45.	Any other pregnancy related condition (if yes, please complete an **adverse event form**)	yes / no
37.	Rhesus disease	yes / no			

Section 5: Medications and treatment

Has she been prescribed any of the following medications?

46.	Aspirin	yes / no	51.	Antibiotics/Antivirals	yes / no
47.	Antihypertensives	yes / no	52.	Corticosteroids	yes / no
48.	Treatments for asthma	yes / no	53.	Magnesium Sulphate	yes / no
49.	Antipsychotics	yes / no	54.	Any other treatment	yes / no
50.	Antidepressants	yes / no	55.	Just bed rest /observation	yes / no

Section 6: Final outcome

56. Final outcome of the admission (cross one box only)

- Discharged ☐
- **Maternal Death** (complete the **pregnancy and delivery** and **adverse event forms**) ☐
- Transferred to another level of care or hospital (please inform study co-ordinator) ☐
- Left hospital or treatment against medical advice (please inform study co-ordinator) ☐
- Delivered/miscarried (complete the **pregnancy and delivery form**) ☐

57. Date of discharge from hospital D D — M M — Y Y

Section 7: Next appointment

If the woman is still pregnant (even if she is still admitted) please check the date of the next ultrasound appointment

58. Date of the next ultrasound appointment D D — M M — Y Y

If the woman is still admitted please inform the study co-ordinator

Name of Researcher	
Signature	
Researcher Code	