

FOLLOW UP FORM FOR PREGNANCY AFTER PROCYSBI

For Office use only

Case Number	
Date received to company:	(dd/mm/yy)

Patient Details :

Patient Information	
Age at time of event or DOB	
Hosp / ID No:	

Description	
Date:	of LMP
of EDD	(dd/mm/yy)

Has positive pregnancy test been confirmed? If yes, what was the test and how was it confirmed ? ☐ Yes ☐ No If yes when? (dd/mm/yy)

Clinical Investigations :

Have any specific tests, e.g. amniocentesis, ultrasound, maternal serum AFP, been performed during the pregnancy so far? ☐ Yes ☐ No If yes when? (dd/mm/yy)

If so what tests and results?

Past Medical History :

Method of contraception?

Was contraception used as intended?

If no, provide details

☐ Yes ☐ No ☐ Uncertain

Is there a previous obstetric history of

☐ termination

☐ stillbirth

Pregnancy *If yes, please provide details and outcome*

Other Medical History :

Information on familial disorders, known risk factors or conditions that may affect the outcome of the pregnancy

Pregnancy Outcome

Abortion

☐ Yes ☐ No If yes : ☐ therapeutic ☐ planned ☐ spontaneous Date :

Please specify the reason and any abnormalities :

Delivery

☐ Yes ☐ No If yes : ☐ vaginal delivery ☐ Forceps/Ventouse ☐ Caesarean section

Date of delivery :

Weeks gestation at time of delivery if available:

Please specify if there were any maternal complications associated with the birth :

Neonatal Outcome

Please describe the birth :

☐ normal ☐ abnormal * ☐ stillbirth

Gender : ☐ male ☐ female

Birth weight :

Length :

Head circumference :

Apgar scores : 1 minute

5 minutes

10 minutes

**Please specify any abnormalities below:*

Mother's obstetrician:

Name: _____

Address: _____

Postcode: _____

Contact details (email or phone)

Date: _____

Reporting ☐ doctor ☐ pharmacist ☐ other:

Name: _____

Address: _____

Postcode: _____

Signature _____

Contact details (email or phone)

Date: _____ (dd/mm/yy)