Severe Chronic Neutropenia International Registry

Patient ID Number: ___/___/___/___/___/___/___
Patient Initials: ___ ___ ___

PREGNANCY REPORTING

Date form completed
Completed by (please print)
Telephone

GENERAL INFORMATION

Patient’s Name: ________________________________

Number of live births: [ ]

Number of still births: [ ]

Number of miscarriages or terminations: [ ]

Is the patient currently pregnant? [ ] No [ ] Yes, expected date of birth: ________________

Has the patient or his/her partner experienced any fertility problem?

[ ] No [ ] Yes [ ] Unknown

If yes, please describe nature of problem: __________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

Please use the back of this form to provide any additional information about patient.

18Nov98
Severe Chronic Neutropenia
International Registry

Patient ID Number: ___/___/___/___
Patient Initials: ___ ___ ___

PREGNANCY REPORTING

Date form completed
Completed by (please print)
Telephone

GENERAL INFORMATION (Complete section once)

Patient’s Name: ________________________________

Primary/Secondary Medical Diagnosis: ________________________________

Number of Births: ☐ Live births ☐ Still births

Number of miscarriages ☐ elective ☐ spontaneous ☐ mother’s medical condition or terminations:
☐ abnormal fetal development

Total number of pregnancies: ☐
(Add number of births and number of miscarriages/terminations.)

Currently pregnant? ☐ No ☐ Yes, expected date of birth: ________________________________

PREGNANCY # ________ OUTCOME (Complete section for each pregnancy)

☐ Miscarriage/termination, please specify reason: ☐ elective ☐ spontaneous
☐ mother’s medical condition ☐ abnormal fetal development

☐ Still birth

☐ Live birth ___/___/___ Date of birth ☐ Male ☐ Female _______ Initials

Weight: _______ Length: _______ Gestational Age: _______

☐ Please provide copy of newborn CBC

Complications during pregnancy (mother or baby)? ☐ No ☐ Yes, describe on back of form.

Congenital abnormalities or other medical problems (baby): ☐ No ☐ Yes, please list all abnormalities or other medical problems on back of form.

Mother nursed infant: ☐ No ☐ Yes If yes, cytokine administered to mother? ☐ No ☐ Yes

Cytokine (growth factor, e.g., G-CSF) administered during pregnancy: ☐ No ☐ Yes

If yes, indicate trimester and cytokine dose: First, _____ ml or mcg or mcg/kg _____ freq
(Circle dose units and indicate frequency.)

Mother’s weight during pregnancy: _____ ☐ lb ☐ kg

Second, _____ ml or mcg or mcg/kg _____ freq

Third, _____ ml or mcg or mcg/kg _____ freq

Did patient stop cytokine treatment? ☐ No ☐ Yes, stop date: ________________________________

Please use the back of this form to provide any additional information about patient or infant.

22Oct98