Form Approved: OMB Control No. 0920-XXXX Exp. XX/XX/XXXX

Human Infection with 2019 Novel Coronavirus
Case Report Form – Pregnancy Module

Pregnant woman:

Complete this form for any woman who is pregnant (any trimester) when confirmed positive for COVID-19.

CDC 2019-nCoV ID: _____ **Reporting Jurisdiction:** _____

CDC pregnancy ID*: _____*This ID is applicable to health departments submitting data for Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET), funded through the Epidemiology Laboratory Capacity: Project W.

State/local case ID: _____ **Contact ID**: _____ **NNDSS loc. Rec. ID/Case ID**: _____

Health insurance at time of COVID-19 infection (check all that apply):
☐ Private ☐ Medicaid ☐ Self-Pay ☐ Other ☐ None ☐ Unknown

Obstetric information:

Gravidity (total pregnancies): _____ **Parity**: (live births) _____
Estimated due date (EDD):__/__/____(MM/DD/YYYY) ☐ Check if EDD is unknown
Number of fetuses ____ (e.g., 1=singleton, 2=twins, 3=triplets) ☐ Check if number of fetuses is unknown
Pre-pregnancy weight: _____lb [or] _____kg **Height**: _____ft _____in [or] _____cm
Did the mother receive prenatal care? ☐ Yes ☐ No ☐ Unknown

Pregnancy conditions (current pregnancy):

Gestational diabetes: ☐ Yes ☐ No ☐ Unknown
Hypertension that started this pregnancy: ☐ Yes ☐ No ☐ Unknown
Intrauterine growth restriction: ☐ Yes ☐ No ☐ Unknown

Trimester of COVID-19 infection:
☐ First (<14 weeks) ☐ Second (14-27 weeks) ☐ Third (≥28 weeks) ☐ Unknown

Treatment for COVID-19:
☐ Remdesivir **Date started:**__/__/____ (MM/DD/YYYY)
☐ Other 1 (**Specify medication**: _____) **Date started**:__/__/____ (MM/DD/YYYY)
☐ Other 2 (**Specify medication**: _____) **Date started**:__/__/____ (MM/DD/YYYY)
☐ Other 3 (**Specify medication**: _____) **Date started**:__/__/____ (MM/DD/YYYY)

For completed pregnancies, please provide the following information:

Date of birth/pregnancy outcome: __/__/____ (MM/DD/YYYY) ☐ Check if date of birth/pregnancy outcome is unknown

Pregnancy outcome (select all that apply):
☐ Miscarriage (<20 weeks gestation)
☐ Stillbirth (≥20 weeks gestation)
☐ Termination
☐ Non-live birth, not otherwise specified
☐ Live birth
☐ Unknown

Was labor induced? ☐ Yes ☐ No ☐ Unknown
If 'yes,' reason for induction (select all that apply):
☐ Past due date/Post-dates
☐ Maternal condition
☐ Fetal condition
☐ Premature rupture of membranes
☐ Other (Specify: _____)
☐ Unknown

Delivery type: ☐ Vaginal ☐ Cesarean ☐ Unknown
If cesarean, indication: ☐ Emergent ☐ Non-emergent ☐ Unknown
If emergent, indication: ☐ Maternal condition ☐ Fetal condition ☐ Both (maternal and fetal)
☐ Unknown ☐ Other (Specify: _____)

Maternal birth hospitalization complications:

Maternal intensive care unit (ICU) admission: ☐ Yes ☐ No ☐ Unknown
If yes, primary reason for ICU admission: _____
Maternal death: ☐ Yes ☐ No ☐ Unknown
If yes, date of death __/__/____ (MM/DD/YYYY) ☐ Check if date of death is unknown
If yes, primary cause of death: _____

Additional comments:

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Enter neonate information on page 2

Neonate (for multiple gestations, please complete one entry for each fetal/infant outcome):
CDC 2019-nCoV ID: _____ **Reporting Jurisdiction:** _____
CDC pregnancy ID*: _____*This ID is applicable to health departments submitting data for Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET), funded through the Epidemiology Laboratory Capacity: Project W.
Contact ID: _____ **State/local case ID**: _____ **NNDSS loc. Rec. ID/Case ID**: _____
Mom CDC 2019-nCoV ID: _____

Sex: ☐ Male ☐ Female ☐ Undetermined ☐ Unknown
Gestational age at delivery: ___weeks ___days
Neonate Birth weight: ___lb ___oz [or] ___kg
Neonate Birth length: ___in [or] ___cm

Infant outcomes (during birth admission):
Neonate intensive care unit admission (any type, NICU, CICU, etc.): ☐ Yes ☐ No ☐ Unknown
If yes, primary reason for ICU admission: _____
Neonate death: ☐ Yes ☐ No ☐ Unknown
If yes, date of death __/__/____ (MM/DD/YYYY) ☐ Check if date of death is unknown
If yes, primary cause of death _____
Birth defect: ☐ Yes ☐ No ☐ Unknown **If yes, specify type**: _____

Neonate COVID-19 testing:
Infant tested for COVID-19 during the birth admission: ☐ Yes ☐ No ☐ Unknown
If tested, result:
☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown
If positive, date of first positive test __/__/____ (MM/DD/YYYY) ☐ Check if date of first positive test is unknown

Birth admission practices:
Did the infant room-in with the mother during the birth admission? ☐ Yes ☐ No ☐ Unknown
Was the infant ever breastfed? ☐ Yes ☐ No ☐ Unknown

Additional comments: