

## 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**

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**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:**