Human Infection with 2019 Novel Coronavirus
Case Report Form – Pregnancy Module 2.0

Pregnant woman: Complete this form for any woman who is pregnant when confirmed positive for COVID-19.

Maternal 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 ELC cooperative agreement: Project W.

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

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

Obstetric Information
Gravida (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 starting 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

Date of first positive specimen by SARS-CoV-2 PCR testing:__/__/____ (MM/DD/YYYY)

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)

Was the mother admitted to an intensive care unit (ICU) for COVID-19?  ☐ Yes  ☐ No  ☐ Unknown
If yes, date of ICU admission:__/__/____ (MM/DD/YYYY)  ☐ Check if date of ICU admission is unknown
Date of ICU discharge:__/__/____ (MM/DD/YYYY)  ☐ Check if date of ICU discharge is unknown

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 (check 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: ____________________________ )  ☐ Unknown

Maternal Birth Hospitalization Complications
Was the mother admitted to an intensive care unit (ICU) for delivery complications?  ☐ Yes  ☐ No  ☐ Unknown
If yes, date of ICU admission:__/__/____ (MM/DD/YYYY)  ☐ Check if date of ICU admission is unknown

Maternal death:  ☐ Yes  ☐ No  ☐ Unknown
If yes, date of death __/__/____ (MM/DD/YYYY)  ☐ Check if date of death is unknown
If yes, cause(s) of death: __________________________________________

Additional comments:

*Enter neonate information on next page*

Public reporting burden of this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1297).
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Neonate (for multiple gestations, please complete one entry for each fetal/infant outcome):
Neonate 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 ELC cooperative agreement: Project W.
Contact ID: ___________ State/local case ID: ___________ NNDSS loc. Rec. ID/Case ID: ___________
Maternal CDC 2019-nCoV ID: __________________

Sex: ☐ Male ☐ Female ☐ Other ☐ Unknown or not yet determined
Gestational age at delivery: ____ weeks ___ days
Was this a multiple gestation pregnancy? ☐ Yes ☐ No ☐ Unknown

Only answer the following questions if this infant was part of a multiple gestation pregnancy. This applies to the variables “Date of
birth/pregnancy outcome” through “delivery type”. For singletons, these variables were captured on the Pregnant Case Form

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

Pregnancy outcome:
☐ 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 (Check 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: ____________________________)

The remainder of this form should be filled out for all neonates.

Neonate birth weight: ___lb ___oz [or] ___kg
Neonate birth length: ___in [or] ___cm

Infant Outcomes (during birth admission)
Was the infant admitted to the intensive care unit (any type, NICU, CICU, etc.)? ☐ Yes ☐ No ☐ Unknown
If yes, date of discharge from the intensive care unit: __/__/____ (MM/DD/YYYY)
Discharge diagnosis codes: __________________________

Neonate death: ☐ Yes ☐ No ☐ Unknown
If yes, date of death __/__/____ (MM/DD/YYYY) ☐ Check if date of death is unknown
If yes, cause(s) of death __________________________

Birth defect: ☐ Yes ☐ No ☐ Unknown ☐ If yes, specify type: __________________________

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

Neonate COVID-19 Testing
Was infant tested for COVID-19 during the birth admission? ☐ Yes ☐ No ☐ Unknown
Test 1:
Type: ☐ SARS-CoV-2 - PCR ☐ SARS-CoV-2 – Antigen ☐ SARS-CoV-2 – IgG ☐ SARS-CoV-2 – IgM
☐ SARS-CoV-2 – Other
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown
Date of sample collection: __/__/____ (MM/DD/YYYY)
Specimen: ☐ Blood ☐ Nasal/NP swab ☐ Throat swab/OP Swab ☐ Combined nasal/NP+throat swab ☐ Sputum
☐ Bronchoalveolar lavage (BAL) ☐ Endotracheal Aspirate (ETA) ☐ Feces/rectal swab ☐ Other
If other, specify type: __________________________
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Test 2:
Type: ☐ SARS-CoV-2 - PCR ☐ SARS-CoV-2 – Antigen ☐ SARS-CoV-2 – IgG ☐ SARS-CoV-2 – IgM
☐ SARS-CoV-2 – Other
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown
Date of sample collection: __/__/____ (MM/DD/YYYY)
Specimen: ☐ Blood ☐ Nasal/NP swab ☐ Throat swab/OP Swab ☐ Combined nasal/NP+throat swab ☐ Sputum
☐ Bronchoalveolar lavage (BAL) ☐ Endotracheal Aspirate (ETA) ☐ Feces/rectal swab ☐ Other
If other, specify type: __________________________

Test 3:
Type: ☐ SARS-CoV-2 - PCR ☐ SARS-CoV-2 – Antigen ☐ SARS-CoV-2 – IgG ☐ SARS-CoV-2 – IgM
☐ SARS-CoV-2 – Other
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown
Date of sample collection: __/__/____ (MM/DD/YYYY)
Specimen: ☐ Blood ☐ Nasal/NP swab ☐ Throat swab/OP Swab ☐ Combined nasal/NP+throat swab ☐ Sputum
☐ Bronchoalveolar lavage (BAL) ☐ Endotracheal Aspirate (ETA) ☐ Feces/rectal swab ☐ Other
If other, specify type: __________________________

Test 4:
Type: ☐ SARS-CoV-2 - PCR ☐ SARS-CoV-2 – Antigen ☐ SARS-CoV-2 – IgG ☐ SARS-CoV-2 – IgM
☐ SARS-CoV-2 – Other
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown
Date of sample collection: __/__/____ (MM/DD/YYYY)
Specimen: ☐ Blood ☐ Nasal/NP swab ☐ Throat swab/OP Swab ☐ Combined nasal/NP+throat swab ☐ Sputum
☐ Bronchoalveolar lavage (BAL) ☐ Endotracheal Aspirate (ETA) ☐ Feces/rectal swab ☐ Other
If other, specify type: __________________________

Test 5:
Type: ☐ SARS-CoV-2 - PCR ☐ SARS-CoV-2 – Antigen ☐ SARS-CoV-2 – IgG ☐ SARS-CoV-2 – IgM
☐ SARS-CoV-2 – Other
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown
Date of sample collection: __/__/____ (MM/DD/YYYY)
Specimen: ☐ Blood ☐ Nasal/NP swab ☐ Throat swab/OP Swab ☐ Combined nasal/NP+throat swab ☐ Sputum
☐ Bronchoalveolar lavage (BAL) ☐ Endotracheal Aspirate (ETA) ☐ Feces/rectal swab ☐ Other
If other, specify type: __________________________

Test 6:
Type: ☐ SARS-CoV-2 - PCR ☐ SARS-CoV-2 – Antigen ☐ SARS-CoV-2 – IgG ☐ SARS-CoV-2 – IgM
☐ SARS-CoV-2 – Other
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown
Date of sample collection: __/__/____ (MM/DD/YYYY)
Specimen: ☐ Blood ☐ Nasal/NP swab ☐ Throat swab/OP Swab ☐ Combined nasal/NP+throat swab ☐ Sputum
☐ Bronchoalveolar lavage (BAL) ☐ Endotracheal Aspirate (ETA) ☐ Feces/rectal swab ☐ Other
If other, specify type: __________________________

Test 7:
Type: ☐ SARS-CoV-2 - PCR ☐ SARS-CoV-2 – Antigen ☐ SARS-CoV-2 – IgG ☐ SARS-CoV-2 – IgM
☐ SARS-CoV-2 – Other
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Unknown
Date of sample collection: __/__/____ (MM/DD/YYYY)
Specimen: ☐ Blood ☐ Nasal/NP swab ☐ Throat swab/OP Swab ☐ Combined nasal/NP+throat swab ☐ Sputum
☐ Bronchoalveolar lavage (BAL) ☐ Endotracheal Aspirate (ETA) ☐ Feces/rectal swab ☐ Other
If other, specify type: __________________________
Test 8:

**Type:**
- ☐ SARS-CoV-2 - PCR
- ☐ SARS-CoV-2 – Antigen
- ☐ SARS-CoV-2 – IgG
- ☐ SARS-CoV-2 – IgM
- ☐ SARS-CoV-2 – Other

**Result:**
- ☐ Positive
- ☐ Negative
- ☐ Indeterminate
- ☐ Unknown

**Date of sample collection:** __/__/____ (MM/DD/YYYY)

**Specimen:**
- ☐ Blood
- ☐ Nasal/NP swab
- ☐ Throat swab/OP Swab
- ☐ Combined nasal/NP+throat swab
- ☐ Sputum
- ☐ Bronchoalveolar lavage (BAL)
- ☐ Endotracheal Aspirate (ETA)
- ☐ Feces/rectal swab
- ☐ Other

If other, specify type: ________________

Test 9:

**Type:**
- ☐ SARS-CoV-2 - PCR
- ☐ SARS-CoV-2 – Antigen
- ☐ SARS-CoV-2 – IgG
- ☐ SARS-CoV-2 – IgM
- ☐ SARS-CoV-2 – Other

**Result:**
- ☐ Positive
- ☐ Negative
- ☐ Indeterminate
- ☐ Unknown

**Date of sample collection:** __/__/____ (MM/DD/YYYY)

**Specimen:**
- ☐ Blood
- ☐ Nasal/NP swab
- ☐ Throat swab/OP Swab
- ☐ Combined nasal/NP+throat swab
- ☐ Sputum
- ☐ Bronchoalveolar lavage (BAL)
- ☐ Endotracheal Aspirate (ETA)
- ☐ Feces/rectal swab
- ☐ Other

If other, specify type: ________________

Test 10:

**Type:**
- ☐ SARS-CoV-2 - PCR
- ☐ SARS-CoV-2 – Antigen
- ☐ SARS-CoV-2 – IgG
- ☐ SARS-CoV-2 – IgM
- ☐ SARS-CoV-2 – Other

**Result:**
- ☐ Positive
- ☐ Negative
- ☐ Indeterminate
- ☐ Unknown

**Date of sample collection:** __/__/____ (MM/DD/YYYY)

**Specimen:**
- ☐ Blood
- ☐ Nasal/NP swab
- ☐ Throat swab/OP Swab
- ☐ Combined nasal/NP+throat swab
- ☐ Sputum
- ☐ Bronchoalveolar lavage (BAL)
- ☐ Endotracheal Aspirate (ETA)
- ☐ Feces/rectal swab
- ☐ Other

If other, specify type: ________________

**Additional comments:**