**Swine Influenza Case Report: Addendum for Pregnant Cases**

*For Pregnant (non-hospitalized) cases, please complete this form in addition to the standard “Swine Influenza Case Report Form”*

*For Pregnant (hospitalized) cases, please also complete the “Clinical Description of Hospitalized Cases”*

FAX to: 404-248-4094 or email to casereportforms@cdc.gov

<table>
<thead>
<tr>
<th>State EPI ID # (epidemiology ID)</th>
<th>CDC EPI ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>State lab specimen ID #1</td>
<td>CDC lab specimen ID #1</td>
</tr>
<tr>
<td>State lab specimen ID #2</td>
<td>CDC lab specimen ID #2</td>
</tr>
<tr>
<td>CDC (lab) unique ID #</td>
<td></td>
</tr>
</tbody>
</table>

Gravidity: _____  Parity: _____

Estimated Date of Delivery (EDC)? (mm/dd/yy):  ___/____/____

Prenatal care:  [ ] Yes  [ ] No  Initiated _____ weeks gestation?

Prenatal testing:
- Any infection/STD diagnosed (includes syphilis, GC, HIV, Chlamydia, hepatitis)?
  - [ ] Yes  [ ] No  Please specify (if yes): ______________________________

- Any birth defects identified prenatally?  [ ] Yes  [ ] No  Please specify (if yes):  ______________________________

Please list any complications during pregnancy including:
- [ ] Gestational diabetes
- [ ] Pre-eclampsia/ pregnancy-induced hypertension
- [ ] Preterm labor
- [ ] Bleeding – If yes, specify diagnosis (i.e. source/cause of bleeding) and estimated gestational age at onset:  ______________________________
- [ ] Other (please specify):  ______________________________

Medications used during pregnancy

- Fever treatment for influenza-like illness during pregnancy:
  - Acetaminophen?  [ ] Yes  [ ] No
  - NSAID?  [ ] Yes  [ ] No

- Antibiotics during pregnancy?  [ ] Yes  [ ] No
  If yes, please specify name of antibiotic, condition treated, treatment dates:

Other medications (please specify):  ______________________________
Outcome, Labor, and Delivery

Date of delivery (mm/dd/yy): ___/____/____
Estimated gestational age at delivery/termination: _______________ (weeks)

Intrapartum Complications:
- [ ] Hemorrhage
- [ ] Chorioamnionitis
- [ ] Other (please specify): _________________________________

Length of labor: ____ hours

Type of delivery
- [ ] Spontaneous abortion
- [ ] Therapeutic abortion
- [ ] Spontaneous vaginal delivery
- [ ] Vacuum-assisted vaginal delivery
- [ ] Forceps-assisted vaginal delivery
- [ ] Cesarean Delivery
  Indication for C-section: ________________________________

Postpartum complications (including postpartum hemorrhage): [ ] Yes 
[ ] No 
If yes, specify: ______________________________________

Was patient febrile during labor and delivery or within 48 hours of delivery?
- [ ] Yes 
- [ ] No

What was diagnosis and how was this treated? __________________________

Infant outcome (if post-partum)
Birth weight in grams: __________
Apgar scores: ______ 1 minute 
______ 5 minute

Admitted to NICU? 
[ ] Yes 
[ ] No 
If yes, Number of days in NICU? _______

Other complications of the newborn during hospitalization (please describe, including any need for resuscitation, signs/symptoms of illness, sepsis, etc.?)
________________________________________________________________________

Date of discharge from hospital (mm/dd/yy): ___/____/____ or death ____/___/_____

Any birth defects noted at birth?: [ ] Yes 
[ ] No 
If yes, please describe: __________________________

Contact information for Attending Physician
Name: ________________________________
Phone: ________________________________