 Study ID |_B_|_3_|--|_0_|--|___|___|___| Patient Initials: |___|___|
Last First

Did the pregnancy result in an abortion (< 28 weeks gestation) ☐ Yes ☐ No if Yes, tick one : ☐ Spontaneous ☐ Elective and date of abortion: |___|___|/|___|___|/|___|___|
day month year
If the pregnancy resulted in an abortion, skip to page 2. If no abortion complete rest of this CRF

Location of delivery: ☐Masafu Hospital ☐TDH ☐Home ☐Other___________________

Key Events	Date (Day/Month/Year)	Time (Hour/Minutes)		N/A
Presentation to facility	|___|___|/|___|___|/|___|___|	|___|___|:|___|___|	AM/PM	☐
CRF started	|___|___|/|___|___|/|___|___|	|___|___|:|___|___|	AM/PM	

Any medications/herbs taken outside the study since last seen?
☐ Yes ☐ No *If no, skip this section*

Medication	Code	Dose *(# of tablets/injections)*	Last date given
			|___|___|/|___|___|/|___|___|
			|___|___|/|___|___|/|___|___|
			|___|___|/|___|___|/|___|___|

LABOR *Could you obtain this information before delivery?* ☐ Yes ☐ No *If no, skip this section*

Date	Time	Temp (°C)	Blood pressure	Oedema*	Urine protein*	Heart rate (mother)	Fetal heart tones	Strength of contractions	Descent of head	Rupture of membranes	Cervical dilatation
/	: am/pm		/				☐ Yes ☐ No	Mild / Mod. / Strong	/ 5 Palp	☐ Yes ☐ No	cm
/	: am/pm		/				☐ Yes ☐ No	Mild / Mod. / Strong	/ 5 Palp	☐ Yes ☐ No	cm
/	: am/pm		/				☐ Yes ☐ No	Mild / Mod. / Strong	/ 5 Palp	☐ Yes ☐ No	cm
/	: am/pm		/				☐ Yes ☐ No	Mild / Mod. / Strong	/ 5 Palp	☐ Yes ☐ No	cm
/	: am/pm		/				☐ Yes ☐ No	Mild / Mod. / Strong	/ 5 Palp	☐ Yes ☐ No	cm
/	: am/pm		/				☐ Yes ☐ No	Mild / Mod. / Strong	/ 5 Palp	☐ Yes ☐ No	cm
/	: am/pm		/				☐ Yes ☐ No	Mild / Mod. / Strong	/ 5 Palp	☐ Yes ☐ No	cm

* 0 / 1+ / 2+ / 3+

Medications given during labor and delivery

Medication	Code	Dose	Frequency

Clinical Notes
(e.g. fetal distress, meconium staining)

Indication for Cesarean if needed ________________________

DELIVERY

Delivery date |___|___|/|___|___|/|___|___| and time |___|___|:|___|___| AM/PM

Mode of delivery ☐Vaginal ☐Cesarean
Number of infants |___| *Fill out separate child delivery CRF for each infant, including stillbirths*

Complications and Delivery Events (tick none or all that apply)

☐NONE	☐PPH after SVD (EBL >500cc)	☐Uterine Rupture	☐Hemorrhage after C/S (EBL >1000cc)
☐Pre-eclampsia (elevated BP + proteinuria)	☐Cephalopelvic dispoportion	☐Injury to fetus	☐Laceration/episiotomy
☐Eclampsia	☐Abruptio placenta	☐Blood transfusion	☐Other ________________________
☐Retained placenta	☐Shoulder dystocia	☐Manual removal of placenta	☐Other ________________________

Entered______ Date__/__/__
Verified______ Date__/__/__

PLACENTAL/CORD SPECIMENS

Were any placental specimens collected? □ Yes □ No If yes, number of placentas ____ If no, reason:_____ *If no, skip to next section*
Were any cord blood specimens collected? □ Yes □ No If yes, number of cords ____ If no, reason:_____

Samples	Placenta/Cord #1	Placenta/Cord #2	Placenta/Cord #3
Placental tissue	□ Collected □ Not collected	□ Collected □ Not collected	□ Collected □ Not collected
Placental blood	□ Collected □ Not collected	□ Collected □ Not collected	□ Collected □ Not collected
Cord blood	□ Collected □ Not collected	□ Collected □ Not collected	□ Collected □ Not collected

LABORATORY TESTS (collect after delivery) □ Collected □ Not collected *If not collected, skip this section*

Specimen collections	Labs	Result [grade]	Initials
CBC/HIV (purple top) □ Collected □ Not collected	WBC *(/mm^3)*	[ ]	
ALT (red top) □ Collected □ Not collected	Neutrophils *(/mm^3)*	[ ]	
Immunology studies (yellow top) □ Collected □ Not collected	Platelets *(/mm^3)*	[ ]	
Filter paper from (complete only if venous, placental or cord blood is collected): Venous blood □ Made □ Not made Placental blood □ Made □ Not made Cord blood standard □ Made □ Not made Cord blood for metabolic testing □ Made □ Not made (cord "b" if twins) □ Made □ Not made	Hemoglobin *(g/dL)*	[ ]	
	ALT (*IU/L)*	[ ]	
Thick and thin blood smear from peripheral blood* (only read urgent if fever) □ Made □ Not made	Other:	[ ]	
Thick blood smear from placental blood □ Made □ Not made	Other:	[ ]	
Thick blood smear from cord blood □ Made □ Not made			
Hemoglobin measurement from cord blood □ Done □ Not done			

HIV Rapid Test (circle one) Positive / Negative / Not done	Thick and Thin smear	Parasite density*(/ul)*	Gametocytes	Species (circle all)	Initials
	Peripheral blood smear		Present / Absent	PF / PM / PO / PV / Unk	
Cord blood Hb level (g/dL)	Placental smear (density only)			(placenta"B" if twins)	
(cord "B" if twins)	Cord blood (density only)			(cord "B" if twins)	

Malaria status: □ No malaria □ Uncomplicated (AL) □ Complicated malaria (quinine or artesunate) □ AL treatment failure (quinine) □ Quinine/artesunate treatment failure (quinine+clinda)

If complicated malaria what criteria (pick all that apply): □ Severe anemia □ Cerebral malaria □ 3 or more seizures over 24 hours □ Respiratory distress □ Other_____

NEW DIAGNOSES AND MEDICATIONS AT DISCHARGE

Diagnosis *	Code	Medication†	Code	Dose	Frequency	Duration to be dispensed

**** List all new diagnoses made during visit*** ***† All pregnant women should be given vitamin A at birth***

Date of discharge if hospitalized |___|___|/|___|___|/|___|___| □ N/A
day month year

Date of next scheduled clinic visit |___|___|/|___|___|/|___|___|
day month year

Initials of person completing form:

Entered_____ Date___/___/___
Verified_____ Date___/___/___