TIP STUDY-STUDY AIM 2:
ANTENATAL ANAEMIA FORM (AAF)

This form needs to be completed on all pregnant patients who are referred to the Antenatal Anaemia Clinic at Chris Hani Baragwanath Hospital.

SUBJECT ID: ☐☐☐☐☐☐ **Today's Date:** ☐☐ / ☐☐ / ☐☐☐☐
Day Month Year

Section 1 - Demographics

1. Age: ☐☐ Years

2. Height ☐☐☐ cm

○ Don't Know

3. Weight at booking ☐☐☐ kg

4a. Residence for the last 12 months

Country _____

City _____

Province ☐☐ Postal Code ☐☐☐☐

4b. Second residency if patient lived in more than one in the past 12 months

Country _____

City _____

Province ☐☐ Postal Code ☐☐☐☐

○ Did not live in more than one place.

5. Nationality

○ South African
○ Africa national

○ Other: _____
○ Don't Know

6. Race / ethnic origin: (Choose one)

○ Black
○ White
○ Coloured
○ Asian

○ Other: _____
○ Don't Know

7. Gravidity
(Number of times pregnant)

☐☐

○ Don't Know

8. Parity (Number of pregnancies carried to viability i.e. through 26 weeks gestation)

☐☐

○ Don't Know

Section 2 – Referring Clinic Data

1. How was the patient referred?

○ Clinic
○ Hospital [SKIP to Section 3]
○ General Practitioner (GP)[SKIP to Sect 3
○ Other [SKIP to Sect 3]

↳ _____

○ Unknown [SKIP to Sect 3]

1a. If referred from the clinic, what is the name of the referring clinic?

_____

1b. Number of visits to the referring antenatal clinic: ☐☐

☐☐☐☐☐

2. Last Hemoglobin at referring clinic:

☐☐.☐ g/dL ○ Unknown

2a. Date it was obtained:

☐☐ / ☐☐ / ☐☐☐☐
Day Month Year

2b. Hemoglobin method used:

- ○ FBC
- ○ Point of Care (e.g. finger stick)
- ○ Other → _____
- ○ Not Done
- ○ Unknown

3. What treatment was the patient taking as prescribed by the <u>referring clinic</u>?

Treatment	<u>Total dosage per day</u>	<u>Date started</u>
a. Iron sulphate	☐☐☐ mg	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year
b. Folic acid	☐☐☐☐☐ µg	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year
c. Vitamin C:	☐☐☐ mg	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year
d. Vitamin A:	☐☐☐ mg	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year
e. Vitamin B12:	☐☐☐ mg	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year
f. Thiamine:	☐☐☐ mg	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year
g. Other iron supplement (specify): _____	☐☐☐ mg	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year

4. Side effects from supplementation?

- ○ Yes
- ○ No
- ○ Unknown

5. Was the patient reported to be compliant with medication at the referring clinic?

- ○ Yes
- ○ No
- ○ Unknown

Section 3 – Evaluation at the Antenatal Anaemia Clinic at CHB

1. Date referred for anaemia: ☐☐ / ☐☐ / ☐☐☐☐

Day Month Year

2. First specialist antenatal anaemia clinic visit date: ☐☐ / ☐☐ / ☐☐☐☐

Day Month Year

3. Gestational age at time of first visit: **#** Weeks: ☐☐ # Days: ☐☐

4. Reason for referral (Mark all):

- ○ Hb<8g/dl: any stage of pregnancy
- ○ Hb<10g/dl: if the patient's gestational age is >36 weeks
- ○ Hb<9g/dl: HIV positive (not on ARVs)
- ○ Hb: Downward trend in hemoglobin
- ○ Hb: Patient not responding to oral iron therapy
- ○ Low Hb
- ○ Signs of severe anaemia (e.g. heart failure, CCF, dyspnea, etc.)
- ○ Specific hematological conditions (specify) } → _____
- ○ Other (specify)
- ○ Unknown

5. What is the tentative diagnosis for the underlying anaemia at the AAC?

Check **ALL** that apply

- ○ Antenatal hemorrhage [SKIP TO Q6.]
- ○ Chronic anaemia

5a. If Chronic anaemia, please be as specific as possible. *(i.e. Rather than anaemia, bleeding or hemorrhage, provide the underlying cause)*

(Mark all that apply.)

- ○ Iron deficiency
- ○ Vitamin B12 deficiency
- ○ Folate deficiency
- ○ Thalassemia
- ○ Sickle cell anaemia
- ○ Hemoglobinopathy or enzyme disorder-other
- ○ Infection
- ○ HIV – ARVs
- ○ HIV- infection
- ○ Medication other
- ○ Anaemia of chronic disease

- ○ Other _____
- ○ Unknown

6. What treatment was the patient taking as prescribed by the AAC?

Treatment	Total dosage per day	Date started
a. Iron sulphate	☐☐☐ mg	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year
b. Folic acid	☐☐☐☐☐ µg	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year
c. Vitamin C:	☐☐☐ mg	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year
d. Vitamin A:	☐☐☐ mg	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year
e. Vitamin B12:	☐☐☐ mg	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year
f. Thiamine:	☐☐☐ mg	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year
g. Other iron supplement (specify): _____	☐☐☐ mg	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year

6a. Has the patient been reported to be compliant with hematinic supplementation?

- ○ Yes
- ○ No
- ○ Unknown

7. Does the patient report side effects from the haematinics while at the clinic?

- ○ Yes
- ○ No [SKIP TO Section 4]
- ○ Unknown [SKIP TO Section 4]

7a. What side effects were experienced? (Mark all that apply.)

- ○ Vomiting
- ○ Heartburn
- ○ Constipation
- ○ Diarrhea
- ○ Other: _____

Section 4 - Pregnancy and Comorbid Medical History

PREVIOUS Pregnancy

1. Previous caesarean sections?

- O Yes
- O No [SKIP TO Q2a]
- O Unknown [SKIP TO Q2a]

1a. How many cesarean sections?

☐☐

2. Delivery complications with PREVIOUS pregnancies?

- O Yes
- O No [SKIP TO Q3]
- O Unknown [SKIP TO Q3]

2a. If yes, what type? (Mark all that apply.)

- O Antepartum hemorrhage
- O Postpartum hemorrhage
- O Blood transfusion
- O Induction of labour
- O Gestation diabetes
- O Gestational proteinuric hypertension
- O TB
- O Antenatal anaemia
- O Malaria
- O Urinary Tract Infections
- O Other infections
- O Other: _____
- O Unknown

3. Please answer the following questions about previous pregnancy history:

	Number (enter zero if none)
a. Number of pregnancies delivered at < 35 weeks	☐☐
b. Number of Still births	☐☐
c. Number of miscarriages	☐☐

CURRENT Pregnancy

4. LMP: ☐☐ / ☐☐ / ☐☐☐☐

Day Month Year

- O Unknown

5. Estimated Date of Delivery:

☐☐ / ☐☐ / ☐☐☐☐

Day Month Year

- O Unknown

6. Booking Date:

☐☐ / ☐☐ / ☐☐☐☐

Day Month Year

- O Unknown

7. Complications during THIS pregnancy?

- O Yes
- O No [SKIP TO Q8.]
- O Unknown [SKIP TO Q8.]

7a. What complications were experienced during THIS pregnancy? (Mark all that apply)

- O Multiple pregnancy
- O Threatened abortion
- O Intrauterine death
- O Antenatal anaemia
- O Diabetes gestational
- O Pre-existing Diabetes from before pregnancy.
- O Malposition:
  - O Breech
  - O Transverse
- O Gestational proteinuric hypertension
- O Intrauterine Growth Retardation (IUGR):
  - O Suspected
  - O Confirmed
- O Decreased liquor
- O Placenta Praevia→ Grade ☐
- O Hypertension
- O Cardiac Disease
- O Renal Disease
- O Syphilis or laboratory evidence of WR
- O Hepatitis B Virus
- O Chorioamnionitis
- O TB-completed treatment this pregnancy
- O TB currently on treatment
- O TB suspected not yet confirmed or treated
- O Malaria
- O Other: _____

8. Has the patient experienced antepartum hemorrhage (APH) or threatened miscarriage during the current pregnancy?

- O Yes
- O No [SKIP TO Q10]
- O Unknown [SKIP TO Q10]

9. What was the <u>primary</u> cause of the Antepartum Hemorrhage?

- O Placenta Previa
- O Threatened abortion
- O Cervicitis
- O Antepartum hemorrhage not specified
- O Other _____
- O Unknown

10. List all medications patient was taking during this pregnancy: (Mark all)

- O Cotrimoxazole (Bactrim)
- O Cephalosporin eg Keflex (cephalexin), cefuroxime
- O Amoxil (amoxicillin)
- O Augmentin (amoxicillin clavulanic acid)
- O Penicilin
- O Piperacilin

Anti TB Drugs

- O Raifafour
- O INH (isoniazid)
- O Pyridoxine

Anti hypertensives

- O Aldomet (methyl dopa)
- O Adalat (nifedipine)
- O Other _____

<u>Vital signs at initial visit to AAC</u>

11. Heart Rate: ☐☐☐
(Beats per minute)
O Unknown

12. Blood pressure:
☐☐☐ / ☐☐☐
O Unknown

13. Respiratory rate: ☐☐☐
(per minute)
O Unknown

14. Temperature: ☐☐.☐ ºC
O Unknown

<u>Section 5 - HIV Status and Treatment</u>

1a. HIV Status of the patient

1a. At booking	O HIV +	O HIV-	O Unknown
If known, date of test:	☐☐ / ☐☐ / ☐☐☐☐		
1b. At Delivery Admissions	O HIV +	O HIV-	O Unknown
If known, date of test:	☐☐ / ☐☐ / ☐☐☐☐		
1c. Other tests during pregnancy	O HIV +	O HIV-	O Unknown
If known, date of test:	☐☐ / ☐☐ / ☐☐☐☐		
1d. Other tests during pregnancy	O HIV +	O HIV-	O Unknown
If known, date of test:	☐☐ / ☐☐ / ☐☐☐☐		

IF NEGATIVE OR UNKNOWN FOR <u>ALL</u>, SKIP TO SECTION 6.

2. Last CD4 count if known (e.g. 382*)*

☐,☐☐☐ cells/mm3

O Unknown

2a. Date of CD4 count from Q2 if known:

☐☐ / ☐☐ / ☐☐☐☐
Day Month Year

O Unknown

3. Last Viral Load: *(example: 12,000)*

☐☐☐,☐☐☐ copies/ml

O Unknown

3a. Date of viral load in question 3:

☐☐ / ☐☐ / ☐☐☐☐
Day Month Year

O Unknown

4. Was patient on ART prior to this pregnancy?

- O Yes
- O No [SKIP TO Q5]
- O Unknown [SKIP TO Q5]

4a. Start Date for ART

☐☐ / ☐☐ / ☐☐☐☐
Day Month Year

○ Unknown

4b. Which ART drugs was the patient taking <u>prior</u> to pregnancy? (Mark all that apply)

○ AZT – Zidovudine/Azidothymidine
○ ddI – Didanosine
○ 3TC – Lamivudine
○ D4T – Stavudine
○ ABC – Abacavir
○ TDF – Tenofovir
○ FTC – Emtricitabine
○ NVP – Nevirapine
○ EFV – Efavirenz
○ ETV – Etravine
○ ATV – Atazanavir
○ LPV/r- - Lopinavir/Ritonavir
○ RAL – Raltegravir
○ SQV – Saquinavir
○ IDV – Indinavir
○ FDC – Fixed Dose Combination – w/AZT
○ FDC – Fixed Dose Combination – w/o AZT

○ Other: _____
○ Unknown

5. Is patient on ART/PMTCT during this pregnancy?

○ Yes
○ No [SKIP TO Q6]
○ Unknown [SKIP TO Q6]

5a. Start Date for ART/PMTCT

☐☐ / ☐☐ / ☐☐☐☐
Day Month Year

5b. Which ART/PMTCT drugs is the patient taking? (Mark all that apply)

○ AZT – Zidovudine/Azidothymidine
○ ddI – Didanosine
○ 3TC – Lamivudine
○ D4T – Stavudine
○ ABC – Abacavir
○ TDF – Tenofovir
○ FTC - Emtricitabine
○ NVP – Nevirapine
○ EFV – Efavirenz
○ ETV - Etravirine
○ ATV – Atazanavir
○ LPV/r – Lopinavir/Ritonavir
○ RAL - Raltegravir
○ SQV - Saquinavir
○ IDV - Indinavir
○ FDC- Fixed Dose Combination – w/AZT
○ FDC – Fixed Dose Combination – w/o AZT
○ Other:
_____

○ Unknown

5c. If patient was taking AZT, when did she begin and end?

Started AZT: ☐☐ / ☐☐ / ☐☐☐☐
Day Month Year

○ Unknown
○ Not taking AZT

Ended AZT: ☐☐ / ☐☐ / ☐☐☐☐
Day Month Year

○ Unknown
○ Not taking AZT
○ Continuing AZT

6. Was the patient HIV positive during the preceding pregnancy?

○ Yes
○ No [SKIP TO Section 6]
○ Not applicable/Primigravida [SKIP TO Section 6]

6a. If yes, was PMTCT used in that pregnancy?

○ Yes
○ No
○ Unknown

☐☐☐☐☐

6b. Was ART used during previous pregnancy?

- ○ Yes
- ○ No
- ○ Unknown

Section 6 –Transfusion

1. Has the patient been transfused during the current pregnancy?

- ○ Yes
- ○ No [SKIP TO END]
- ○ Unknown [SKIP TO END]

2. If Yes, date of transfusion:

☐☐ / ☐☐ / ☐☐☐☐

Day Month Year

3. Number of units transfused: ☐☐

4. Where was the patient when the blood transfusion was started?

- ○ Antenatal
- ○ Gynaecology
- ○ Theatre
- ○ Casualty
- ○ Medical
- ○ Surgical
- ○ ICU
- ○ Outpatient
- ○ Other _____
- ○ Unknown

Section 7 – NOTES:

Note: Please print clearly in all capital letters.

End of Form