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

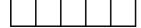
This form needs to be completed on all pregnant patients who are referred to the Antenatal Anaemia Clinic at Chris Hani Baragwanath Hospital. SUBJECT ID: Today's Date: Day Month Year **Section 1 - Demographics** 6. Race / ethnic origin: (Choose one) O Black 1. Age: O White O Coloured O Asian 2. Height cm O Other: O Don't Know O Don't Know 7. Gravidity 3. Weight at booking kg (Number of times pregnant) 4a. Residence for the last 12 months O Don't Know Country 8. Parity (Number of pregnancies carried to viability i.e. through 26 weeks gestation) City O Don't Know Province Postal Code Section 2 - Referring Clinic Data 4b. Second residency if patient lived in more than one in the past 12 months 1. How was the patient referred? O Clinic Country O Hospital [SKIP to Section 3] O General Practitioner (GP)[SKIP to Sect 3 OOther [SKIP to Sect 3] City OUnknown [SKIP to Sect 3] Postal Code **Province** 1a. If referred from the clinic, what is the name of the referring clinic? O Did not live in more than one place. 5. Nationality O South African 1b. Number of visits to the referring antenatal O Africa national clinic:



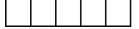
O Other:
O Don't Know



2. Last Hemoglobin at referring clinic:				
g/dL O Unknown				
2a. Date it was obtained:				
Day Month Year				
2b. Hemoglobin method used: O FBC O Point of Care (e.g. finger stick) O Other O Not Done O Unknown				
3. What treatment was the patient taking as prescribed by the <u>referring clinic</u> ?				
Treatment	Total dosage per day	Date started		
a. Iron sulphate	mg	Day Month Year		
b. Folic acid	μд	Day Month Year Day Month Year Pay Month Year		
c. Vitamin C:	mg mg	Day Month Year		
d. Vitamin A:	mg mg	Day Month Year		
e. Vitamin B12:	mg			
f. Thiamine:	mg	Day Month Year Day Month Year Pay Month Year		
g. Other iron supplement (specify):	mg	Day Month Year		
4. Side effects from supplementation? 5. Was the patient reported to be compliant with medication at the referring clinic?				
O Yes O No O Unknown	O Y O N O U			









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	μд	//		
		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 l			
		Day Month Year		
g. Other iron supplement (specify):	mg			
g:				
		Day Month Year		
6a. Has the patient been reported to be compliant with hematinic supplementation? O Yes O No O Unknown 7. Does the patient report side effects from the haematinics while at the clinic? O Yes O No [SKIP TO Section 4] O Unknown [SKIP TO Section 4] O Unknown [SKIP TO Section 4] 7a. What side effects were experienced? (Mark all that apply.) O Vomiting O Heartburn O Constipation				
O Diarrhea O Other:				



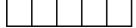
Section 4 - Pregnancy and

Section 4 - Pregnancy and	5. Estimated Date of Delivery:
Comorbid Medical History PREVIOUS Pregnancy	
1. Previous caesarean sections?	Day Month Year O Unknown
O Yes O No [SKIP TO Q2a] O Unknown [SKIP TO Q2a]	6. Booking Date:
1a. How many cesarean sections?	Day Month Year O Unknown
2. Delivery complications with PREVIOUS pregnancies? O Yes O No [SKIP TO Q3] O Unknown [SKIP TO Q3]	7. Complications during THIS pregnancy? O Yes O No [SKIP TO Q8.] O Unknown [SKIP TO Q8.] 7a. What complications were experienced
2a. If yes, what type? (Mark all that apply.)	during THIS pregnancy? (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: O Unknown 3. Please answer the following questions about previous pregnancy history: Number (enter zero if none)	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
CURRENT Pregnancy	O Malaria O Other:
4. LMP: / / / / / / / / / / / / / / / / / / /	
Day Month Year	
O Unknown	





8. Has the patient experienced antepartum hemorrhage (APH) or threatened miscarriage during the current pregnancy?	Section 5 - HIV Status and Treatment						
O Yes	1a. HIV Status of th	e patie	ent				
O No [SKIP TO Q10] O Unknown [SKIP TO Q10]	1a. At booking	O HIV +		O HIV-	O		
9. What was the <u>primary</u> cause of the Antepartum Hemorrhage?	If known, date of test:		/[/		
O Placenta Previa O Threatened abortion	1b. At Delivery Admissions	O HIV +	ı	O HIV-	O Unknov	wn	
O Cervicitis O Antepartum hemorrhage not specified	If known, date of test:		/		/		
O Other	1c. Other tests during pregnancy	O HIV +		O HIV-	O Unkn	own	
10. List all medications patient was taking	If known, date of test:		/		/		
during this pregnancy: (Mark all)	1d. Other tests during pregnancy	O HIV +		O HIV-	O Unkne	own	
O Cotrimoxazole (Bactrim) O Cephalosporin eg Keflex (cephalexin), cefuroxime	If known, date of test:		/		/ [
O Amoxil (amoxicillin) O Augmentin (amoxicillin clavulanic acid) O Penicilin	IF NEGATIVE OR UNKNOWN FOR <u>ALL</u> , SKIP TO SECTION 6.						
O Piperacilin Anti TB Drugs	2. Last CD4 count if known (e.g. 382) cells/mm3						
O Raifafour O INH (isoniazid)							
O Pyridoxine Anti hypertensives							
O Aldomet (methyl dopa) O Adalat (nifedipine) O Other	2a. Date of CD4 count from Q2 if known:						
Vital signs at initial visit to AAC	Day Month	Ye	ar				
11. Heart Rate:	O Unknown	/avamı	ala i	10.00	0)		
(Beats per minute) O Unknown	3. Last Viral Load:	(exam _l					
12. Blood pressure:	C Unknown						
O Unknown 13. Respiratory rate: (per minute) O Unknown	3a. Date of viral loa Day Month	d in qu	ues	tion 3	:		
14. Temperature: °C	O Unknown						
O Unknown	4. Was patient on A pregnancy? O Yes O No [SKIP TO O Unknown [S	O Q5]			•		





4a. Start Date for ART	5b. Which ART/PMTCT drugs is the patient taking? (Mark all that apply)
Day Month Year O Unknown	O AZT – Zidovudine/Azidothymidine O ddl – Didanosine O 3TC – Lamivudine O D4T – Stavudine O ABC – Abacavir O TDF – Tenofovir
4b. Which ART drugs was the patient taking prior to pregnancy? (Mark all that apply) O AZT – Zidovudine/Azidothymidine	O FTC - Emtricitabine O NVP – Nevirapine O EFV – Efavirenz O ETV - Etravirine O ATV – Atazanavir
O ddl – Didanosine O 3TC – Lamivudine O D4T – Stavudine O ABC – Abacavir O TDF – Tenofovir O FTC – Emtricitabine O NVP – Nevirapine O EFV – Efavirenz O ETV – Etravine	O LPV/r – Lopinavir/Ritonavir O RAL - Raltegravir O SQV - Saquinavir O IDV - Indinavir O FDC- Fixed Dose Combination – w/AZT O FDC – Fixed Dose Combination – w/o AZT O Other:
O ATV – Atazanavir O LPV/r Lopinavir/Ritonavir O RAL – Raltegravir O SQV – Saquinavir O IDV – Indinavir O FDC – Fixed Dose Combination – w/AZT O FDC – Fixed Dose Combination – w/o AZT	O Unknown 5c. If patient was taking AZT, when did she begin and end? Started AZT: / / /
O Other: O Unknown	O Unknown O Not taking AZT
5. Is patient on ART/PMTCT during this pregnancy? O Yes O No [SKIP TO Q6]	Ended AZT: Day Month Year Unknown Not taking AZT Continuing AZT
O Unknown [SKIP TO Q6] 5a. Start Date for ART/PMTCT	6. Was the patient HIV positive during the preceding pregnancy?
Day Month Year	O YesO No [SKIP TO Section 6]O Not applicable/Primigravida [SKIP TO Section 6]
	6a. If yes, was PMTCT used in that pregnancy?
	O Yes O No O Unknown





6b. Was ART used during previous pregnancy?	Section 7 – NOTES: Note: Please print clearly in all capital
O Yes O No O Unknown	letters.
Section 6 –Transfusion	
1. Has the patient been transfused during the current pregnancy?	
O Yes O No [SKIP TO END] O 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?	End of Form
O Antenatal O Gynaecology O Theatre O Casualty O Medical O Surgical O ICU O Outpatient	
O Other —	
O Unknown	

