COVID-19 Maternal & Infant Outcomes Case Ascertainment Form

The New Jersey Department of Health (NJDOH) is investigating maternal and infant outcomes in cases of COVID-19 infection during pregnancy. This form should be used to identify cases of women at any stage of pregnancy who test positive for COVID-19. The NJDOH team will coordinate additional data collection as necessary. *Please note this is a dynamic situation and this form may be modified or changed.*
Submission Instructions: Scan and send via secure email to: pregnantcovid@doh.nj.gov **or** Fax to: 609-633-7820 **or** Mail to: COVID Pregnancy Outcomes, SCHEIS, PO Box 364, Trenton, NJ 08625-0364

Name of Person Completing Form: _____ Email or Phone #: _____

Pregnant woman: shaded section indicates minimum required fields for submission

First & Last Name: _____ DOB: _____
Estimated Due Date: _____ ☐ Check if EDD confirmed via ultrasound ☐ EDD Unknown

Gravida	Para	Full Term	Preterm	Ab	Living

Health insurance at time of COVID-19 infection:
☐Private ☐Medicaid ☐Self-Pay ☐Charity Care ☐Other ☐None ☐Unknown

COVID-19 treatment location was:
☐ Outpatient only
☐ Inpatient hospital admission with a final pregnancy outcome (birth, stillbirth, spontaneous or induced abortion). Note: Length of treatment location will be captured on page 2.
☐ Inpatient hospital admission, discharged still pregnant. If selected, please complete length of stay:

Treatment location	L&D/Maternity	Respiratory or medical unit	ICU*
Total # of days in location			

*If ICU admission, primary reason:_____

COVID-19 infection was: ☐ Asymptomatic ☐ Symptomatic

Treatment for COVID-19:
☐ Remdesivir **Date started:**_____
☐ Other 1 **Specify medication**:_____ **Date started**:_____
☐ Other 2 **Specify medication**:_____ **Date started**:_____
☐ Other 3 **Specify medication**:_____ **Date started**:_____

Pregnancy outcome(s) (if multiple gestation, select all that apply):
☐ Ectopic pregnancy
☐ Spontaneous abortion (<20 weeks gestation)
☐ Induced abortion
☐ Fetal death (≥20 weeks gestation)
☐ Non-live birth, not otherwise specified
☐ Live birth
☐ Not yet delivered
☐ Unknown

If outcome is fetal death (>20 wks), complete page 2 (Delivery). If outcome is live birth, complete page 2 &3 (Delivery & Neonate). Otherwise return form for DOH to monitor for delivery status.

Delivery Information

Mother Name: _____ Mother DOB: _____
Estimated Due Date: _____ ☐ Check if EDD confirmed via ultrasound ☐ EDD Unknown

Total number of prenatal visits completed via telehealth: _____
Date of delivery: _____

Delivery admission care location:	**L&D/Maternity**	**Respiratory or medical unit**	**ICU***
Total # of days in location			

*If ICU admission, primary reason:_____

If labor was induced, reason for induction (select all that apply)? (skip if not induced)
☐ Past due date/Post-dates
☐ Maternal condition, Specify: _____
☐ Fetal condition, Specify: _____
☐ Premature rupture of membranes
☐ Other, Specify: _____
☐ Unknown

If cesarean delivery, specify indication: _____(skip if no cesarean)
Was cesarean:
☐Emergent
- ☐Maternal condition
- ☐Fetal condition
- ☐Both (maternal and fetal)
- ☐Unknown
- ☐Other

☐Non-emergent
☐Unknown

If Maternal death:
Primary cause of death:_____

Neonate(s) Information:

Mother Name: _____ Mother DOB: _____
Estimated Due Date: _____ ☐ Check if EDD confirmed via ultrasound ☐ EDD Unknown

	Singleton/Baby A	Baby B	Baby C
Medical Record # or CaseID			
Neonate Birth length	____in [or] ____cm	____in [or] ____cm	____in [or] ____cm
Was skin-to-skin contact initiated in the first hour after delivery?	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Is there documentation of shared decision-making regarding rooming in?	☐ Yes ☐ No ☐ Unknown ☐ N/A (mom in ICU)	☐ Yes ☐ No ☐ Unknown ☐ N/A (mom in ICU)	☐ Yes ☐ No ☐ Unknown ☐ N/A (mom in ICU)
Did the infant room-in with the mother during the birth admission?	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Was the infant ever breastfed?	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
If NICU admission, primary reason for NICU admission			
Specify any birth defect			
If neonatal death, primary cause of death			
Was infant tested for COVID-19 *during the birth admission*?	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Infant COVID test results: Document the FIRST *inpatient* test. If the first test is negative and a subsequent *inpatient* test is positive, use #2 fields to document the FIRST POSITIVE *inpatient* test			
Infant test result date #1			
Infant test result type #1	☐ PCR ☐ IgG ☐ IgM	☐ PCR ☐ IgG ☐ IgM	☐ PCR ☐ IgG ☐ IgM
Infant test result #1	☐ Negative ☐ Positive ☐ Unknown	☐ Negative ☐ Positive ☐ Unknown	☐ Negative ☐ Positive ☐ Unknown
Infant test result date #2			
Infant test result type #2	☐ PCR ☐ IgG ☐ IgM	☐ PCR ☐ IgG ☐ IgM	☐ PCR ☐ IgG ☐ IgM
Infant test result #2	☐ Negative ☐ Positive ☐ Unknown	☐ Negative ☐ Positive ☐ Unknown	☐ Negative ☐ Positive ☐ Unknown