Lenalidomide
Event-Specific Questionnaire for HCP - Pregnancy Outcome Form
(Patient or Partner of Patient)

This form must be returned to the MAH who provided the product. Please see contact details below:

NOTE: Please use the first three letters of the month (e.g.: JAN)

Reporter information

Reporter Name:	
Address:	
City, County, Country:	
Phone No.:	
Fax No.:	

Patient information

Patient ID: | Date of Birth: D D M O N Y Y Y Y | Ethnicity:

Partner of patient information

○ Not applicable | Ethnicity:

Pregnancy outcome

Date of delivery: D D M O N Y Y Y Y | Gestation age at delivery:

Normal	○ No	○ Yes
C-section	○ No	○ Yes
Induced	○ No	○ Yes
Ectopic pregnancy	○ No	○ Yes
Elective termination	○ No	○ Yes
Spontaneous abortion (≤20 weeks)	○ No	○ Yes
Foetal death/stillbirth (>20 weeks)	○ No	○ Yes
Were the products of conception examined?	○ No	○ Yes

Date: D D M O N Y Y Y Y
Weeks from LMP:

If yes, was the foetus normal? ○ No ○ Yes ○ Unknown If no, describe below:

Obstetrics information

Complications during pregnancy	○ No	○ Yes	If yes, please specify
Complications during labour/delivery	○ No	○ Yes	If yes, please specify
Post-partum maternal complications	○ No	○ Yes	If yes, please specify

Foetal outcome

Live normal infant	○ No	○ Yes	
Foetal distress	○ No	○ Yes	
Intra-uterine growth retardation	○ No	○ Yes	
Neonatal complication	○ No	○ Yes	If yes, please specify
Birth defect noted?	○ No	○ Yes	If yes, please specify

Sex: ○ Male ○ Female Birth weight: ____ lbs ____ oz. or ____ kg Length: ____ inches or ____ cm.

Apgar score: 1 min: ____ 5 min: ____ 10 min: ____ ○ Unknown

Signature of person completing this form

Signature: | Date: D D M O N Y Y Y Y

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Reporter's Signature (required):

Signature:	Date signed:	D	D	M	O	N	Y	Y	Y	Y

Thank you for providing information that will assist us in our commitment to patient safety.