Pregnancy reports must be sent to the relevant Medical information team IMMEDIATELY

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Date of awareness: D D M O N Y Y Y Y

Patient Data

Sex of Patient: ◯ Female ◯ Male

◯ Pregnancy of Patient

◯ Pregnancy of Patient's Partner **OR**

◯ Exposure of a Pregnant Female (complete information below)

Pregnant Woman's Initials (F, M, L):	Date of Birth: D D M O N Y Y Y Y	Age:
Patient Initials (F, M, L): (Who received drug)	Date of Birth: D D M O N Y Y Y Y	Age:
Drug Name:		
Date of First Dose: D D M O N Y Y Y Y	Date of Last Dose: D D M O N Y Y Y Y	

Pregnancy Initially Diagnosed By:

◯ Home Urine Test

◯ Office Urine Test

◯ Serum Test

Date of Pregnancy Test: D D M O N Y Y Y Y | Last Menstrual Period: D D M O N Y Y Y Y

Female is Currently: ____ weeks pregnant **OR** ◯ No longer Pregnant ◯ Unknown

Female has Elected to: ◯ Carry Pregnancy to Term | Expected Date of Delivery: D D M O N Y Y Y Y

◯ Terminate Pregnancy | Date Performed or Pending: D D M O N Y Y Y Y

Reporter's Information:

Reporter's Name:		Date:	D D M O N Y Y Y Y
Reporter's Contact Information/ Address:		Reporter's Signature:	
		Reporter's Phone Number:	
Reporter's E-mail Address:			

Patient's Prescribing Physician's Information:

Physician's Name:		Date:	D D M O N Y Y Y Y
Physician's Contact Information/ Address:		Physician's Signature:	
		Physician's Phone Number:	

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Physician's E-mail Address:		Physician's Fax Number:	

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Background Information on Reason for Pregnancy

Was patient erroneously considered not to be of childbearing potential?	◯ Yes	◯ No
If yes, state reason for considering not to be of childbearing potential		
• Age ≥ 50 years and naturally amenorrhoeic* for ≥ 1 year *amenorrhoea following cancer therapy or during breastfeeding does not rule out childbearing potential	◯ Yes	◯ No
• Premature ovarian failure confirmed by a specialist gynaecologist	◯ Yes	◯ No
• Previous bilateral salpingo-oophorectomy, or hysterectomy	◯ Yes	◯ No
• XY genotype, Turner syndrome, uterine agenesis.	◯ Yes	◯ No
Indicate from the list below what contraception was used		
• Implant	◯ Yes	◯ No
• Levonorgestrel-releasing intrauterine system (IUS)	◯ Yes	◯ No
• Medroxyprogesterone acetate depot	◯ Yes	◯ No
• Tubal sterilization (specify below)	◯ Yes	◯ No
○ Tubal ligation	◯ Yes	◯ No
○ Tubal diathermy	◯ Yes	◯ No
○ Tubal chips	◯ Yes	◯ No
• Sexual intercourse with a vasectomized male partner only; vasectomy must be confirmed by two negative semen analyses	◯ Yes	◯ No
• Ovulation inhibitory progesterone-only pills (i.e. desogestrel)	◯ Yes	◯ No
• Other progesterone-only pills	◯ Yes	◯ No
• Combined oral contraceptive pill	◯ Yes	◯ No
• Other intra-uterine devices	◯ Yes	◯ No
• Condoms	◯ Yes	◯ No
• Cervical cap	◯ Yes	◯ No
• Sponge	◯ Yes	◯ No
• Withdrawal	◯ Yes	◯ No
• Other	◯ Yes	◯ No
• None	◯ Yes	◯ No
Indicate from the list below the reason for contraceptive failure		
• Missed oral contraception	◯ Yes	◯ No
• Other medication or intercurrent illness interacting with oral contraception	◯ Yes	◯ No
• Identified mishap with barrier method	◯ Yes	◯ No
• Unknown	◯ Yes	◯ No
• Had the patient committed to complete and continuous abstinence	◯ Yes	◯ No
• Was the drug started despite patient already being pregnant	◯ Yes	◯ No
• Did patient receive educational materials on the potential risk of teratogenicity	◯ Yes	◯ No
• Did patient receive instructions on need to avoid pregnancy	◯ Yes	◯ No

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Background Information on Reason for Pregnancy

Prenatal information

Date of Last Menstrual Period:	D D M O N Y Y Y Y	Expected Delivery Date:	D D M O N Y Y Y Y

Pregnancy test

Urine Qualitative ◯	Reference Range:	Date:	D D M O N Y Y Y Y
Serum Quantitative ◯	Reference Range:	Date:	D D M O N Y Y Y Y

Past Obstetric History

Year of Pregnancy	Outcome	Gestational Age	Type of Delivery
Y Y Y Y	◯ Spontaneous abortion ◯ Therapeutic abortion ◯ Live birth ◯ Still birth		
Y Y Y Y	◯ Spontaneous abortion ◯ Therapeutic abortion ◯ Live birth ◯ Still birth		
Y Y Y Y	◯ Spontaneous abortion ◯ Therapeutic abortion ◯ Live birth ◯ Still birth		
Y Y Y Y	◯ Spontaneous abortion ◯ Therapeutic abortion ◯ Live birth ◯ Still birth		
Y Y Y Y	◯ Spontaneous abortion ◯ Therapeutic abortion ◯ Live birth ◯ Still birth		

Birth defects

Was there any birth defect from any pregnancy?	◯ Yes	◯ No	◯ Unknown
Is there any family history of any congenital abnormality abstinence?	◯ Yes	◯ No	◯ Unknown

If yes to either of these questions, please provide details below:

Maternal Past Medical History

Condition	Dates	Treatment	Outcome
	From: D D M O N Y Y Y Y To: D D M O N Y Y Y Y		
	From: D D M O N Y Y Y Y To: D D M O N Y Y Y Y		
	From: D D M O N Y Y Y Y To: D D M O N Y Y Y Y		
	From: D D M O N Y Y Y Y To: D D M O N Y Y Y Y		
	From: D D M O N Y Y Y Y To: D D M O N Y Y Y Y		

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Maternal Current Medical Conditions

Condition	From	Treatment
	D D M O N Y Y Y Y	
	D D M O N Y Y Y Y	
	D D M O N Y Y Y Y	
	D D M O N Y Y Y Y	
	D D M O N Y Y Y Y	
	D D M O N Y Y Y Y	
	D D M O N Y Y Y Y	

Maternal Social History

Alcohol ○ Yes ○ No

If yes, amount/units per day:

Tobacco ○ Yes ○ No

If yes, amount per day:

IV or recreational drug use ○ Yes ○ No

If yes, provide details:

Maternal medication during pregnancy and in 4 weeks before pregnancy

(including herbal, alternative and over the counter medicines and dietary supplements)

Medication/treatment	Dates		Indication
	Start Date:	D D M O N Y Y Y Y	
	Stop Date/Continuing:	D D M O N Y Y Y Y	
	Start Date:	D D M O N Y Y Y Y	
	Stop Date/Continuing:	D D M O N Y Y Y Y	
	Start Date:	D D M O N Y Y Y Y	
	Stop Date/Continuing:	D D M O N Y Y Y Y	
	Start Date:	D D M O N Y Y Y Y	
	Stop Date/Continuing:	D D M O N Y Y Y Y	
	Start Date:	D D M O N Y Y Y Y	
	Stop Date/Continuing:	D D M O N Y Y Y Y	
	Start Date:	D D M O N Y Y Y Y	
	Stop Date/Continuing:	D D M O N Y Y Y Y	

Name of person completing this form

Name:

Date: D D M O N Y Y Y Y

Signature:

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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.