Pomalidomide
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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Drug Safety Data Privacy notice

Your personal data will be processed by the relevant marketing authorisation holder, and its worldwide affiliates, to the extent and for as long as necessary, for the purposes of the compliance with drug safety legal obligations and for storage purposes. Should you have any queries in relation to the use of your personal data please contact the relevant marketing authorisation holder.

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.