Baseline Assessment Case Report Form

A. Demographic Data

1. Date of baseline visit: D D M M M Y Y Y Y

2. Age at randomization: ☐☐ Years

3. Race/Ethnicity (may choose more than one):

- ☐ White/Caucasian
- ☐ Black/African Heritage
- ☐ Indigenous
- ☐ Asian/South East Asian
- ☐ Hispanic/Latino
- ☐ Pacific Islander

4. Height and weight prior to this pregnancy (can be reported by the subject):

Pre-pregnancy weight: ________________ ☐ kg ☐ lbs

Height: ____________________________ ☐ cm ☐ feet/inches

Pre-pregnancy BMI: __________________ (kg/m^2)

If pre-pregnancy weight unknown, use subject's reported weight in 1st trimester

5. Current maternal weight (can be reported by the subject): ___________ ☐ kg ☐ lbs

6. Smoking history:

Current smoker? ☐ Yes ☐ No

Number of cigarettes per day (average over past year): ☐☐

Previous smoker? ☐ Yes ☐ No

If yes, quit date: M M M Y Y Y Y

Number of cigarettes per day (average over year prior to quitting): ☐☐

B. Medical History

1. Has any related family members had a VTE?

☐ No ☐ First degree relative ☐ Second degree relative

2. Prior medical issues?

☐ **No prior medical issues** ☐ **Yes**, please check all that apply:

- ☐ Systemic lupus erythematosus (SLE, lupus)
- ☐ Sickle cell disease
- ☐ Inflammatory bowel disease
- ☐ Hypertension (prior to pregnancy)
- ☐ Type 1 diabetes (prior to pregnancy)
- ☐ Type 2 diabetes (prior to pregnancy)
- ☐ Known kidney disease: ____________________
- ☐ Known cardiac disease: ____________________

3. Previous history of superficial vein thrombosis? ☐ Yes ☐ No

If yes, confirmed by ultrasound? ☐ Yes ☐ No

If yes, pregnancy or postpartum related? ☐ Yes ☐ No

If yes, exogenous estrogen related? ☐ Yes ☐ No

4. **Previous history of varicose veins?** *(soft, dilated, large superficial veins)* ☐ Yes ☐ No

C. Obstetrical History

1. **Parity:**

   Number of pregnancies carried past 20 weeks gestation (including current pregnancy): ☐☐

2. **Prior cesarean delivery** (not including current pregnancy)? ☐ Yes ☐ No

3. **Did the subject have any complications during PRIOR pregnancies?**

   ☐ **No complications** ☐ **Yes PRIOR complications**, please check all that apply:

   - ☐ Gestational hypertension
   - ☐ Pre-eclampsia

     Largest amount of proteinuria documented if known:

     Urine protein / Cr ratio: _________ mg/mmol spot urine

     OR 24-hour urine protein: _________ grams
   - ☐ Eclampsia (seizures)
   - ☐ HELLP syndrome
   - ☐ Gestational diabetes
   - ☐ Pregnancy loss
     - ☐ <10 weeks gestation Number of losses: ☐☐
     - ☐ 10-20 weeks gestation Number of losses: ☐☐
     - ☐ >20 weeks gestation Number of losses: ☐☐
     - ☐ Unknown timing Number of losses: ☐☐
   - ☐ Intrauterine growth restriction or small-for gestational age
   - ☐ Placental abruption
   - ☐ Intrapartum infection (e.g. chorioamnionitis)
   - ☐ Postpartum infection

D. Current Pregnancy

1. **Method of conception:**

   ☐ Spontaneous ☐ Ovulation induction with medical therapy

   ☐ Intrauterine insemination ☐ In vitro fertilisation (IVF) or Intracytoplasmic sperm injection

2. **Aspirin use in current pregnancy:** ☐ Yes ☐ No

   If yes, dose per day: ___________ mg

   Gestational age when aspirin started: ☐☐ weeks + ☐ days

   Date of last dose: D D M M M Y Y Y Y

3. Immobilization in current pregnancy:

Any type of bedrest at any point during pregnancy? ☐ Yes ☐ No

If yes, total days immobilized during this pregnancy: ☐☐

Bedrest at home? ☐ Yes ☐ No

Hospitalized for bedrest? ☐ Yes ☐ No

Type of bedrest (choose all that apply):

- ☐ Strict bedrest (>90% of time, bathroom privileges)
- ☐ Modified bedrest (Limited walking, restricted activities)

Reason for bedrest: ______________________________

Number of episodes of bedrest: ☐☐

Gestational age at **start** of bedrest closest to delivery: ☐☐ weeks + ☐ days

Gestational age at **end** of bedrest closest to delivery: ☐☐ weeks + ☐ days

E. Delivery Details

1. Date of admission for labor/delivery: D D M M M Y Y Y Y

2. Date of delivery of infant: D D M M M Y Y Y Y

3. Date and time of delivery of placenta: D D M M M Y Y Y Y

H H M M

4. Gestational age at delivery: ☐☐ weeks + ☐ days

5. Singleton or multiple pregnancy: ☐ Single ☐ Multiple pregnancy

6. Type of Labor:

- ☐ Spontaneous labor
- ☐ Induction of labor, reason if known: ______________________________
- ☐ No labor (e.g. scheduled cesarean delivery)

7. Mode of Delivery:

- ☐ Vaginal delivery
  - ☐ Unassisted vaginal delivery
  - ☐ Assisted vaginal delivery (forceps/vacuum)
- ☐ Manual removal of placenta following vaginal delivery
- ☐ Cesarean delivery
  - ☐ Scheduled/planned cesarean delivery
  - ☐ Unplanned or emergency cesarean delivery, reason if known:

____

8. Was the placenta previa or abnormally invasive? ☐ Yes ☐ No

9. Did the subject receive neuraxial anesthesia? ☐ Yes ☐ No

10. Was the subject's active labor prolonged >24 hours? ☐ Yes ☐ No

11. Postpartum hemorrhage?

☐ Yes ☐ No ☐ Unknown

If yes, estimated blood loss: ☐☐☐☐ mL

Estimated blood loss measured by: ☐ Visual estimate
☐ Counting/weighing pads or bedding

12. Did the subject receive a red blood cell transfusion?

☐ Yes, number of units ☐☐ ☐ No

13. Did the subject have any complications during the <u>CURRENT</u> pregnancy?

☐ **No complications** ☐ **Yes CURRENT pregnancy complications ,** please check all that apply:

- ☐ Gestational hypertension
- ☐ Pre-eclampsia

  Largest amount of proteinuria documented:

  Urine protein / Cr ratio: _________ mg/mmol spot urine

  OR 24-hour urine protein: _________ grams

- ☐ Eclampsia (seizures)
- ☐ HELLP syndrome
- ☐ Gestational diabetes
- ☐ Intrauterine growth restriction or small-for gestational age
- ☐ Placental abruption
- ☐ Intrapartum infection (e.g. chorioamnionitis)
- ☐ Postpartum infection

14. Laboratory results:

Last known hemoglobin count: ________ g/L ☐ Pre-delivery ☐ Postpartum

Date of result: D D M M M Y Y Y Y

Last known platelet count: ________ x 10^9/L ☐ Pre-delivery ☐ Postpartum

Date of result: D D M M M Y Y Y Y

COVID-19 status in the last 14 days?

☐ Positive result ☐ Negative result

☐ Pending result ☐ Unknown result/Not done

Date of test: D D M M M Y Y Y Y

If **pending**, indicate final result: ☐ Positive ☐ Negative

F. Infant Details

1. Current pregnancy: Infant sex and weight:

Infant	Live birth (Y/N)	Sex (M/F)	Weight (g)
A			
B			
C			

G. Immediate Postpartum Details

1. Date and time of first mobilization after delivery (as reported by subject):

Date and time: D D M M M Y Y Y Y

H H M M

2. Use of pneumatic compression devices, graduated compression or TED stockings since delivery?

☐ **Yes,** please specify the type used: ☐ No

☐ Pneumatic compression device Number of days used: ☐☐

☐ Graduated compression stockings Number of days used: ☐☐

☐ TED stockings (<20 mmHg) Number of days used: ☐☐

3. Has the subject received low-molecular-weight-heparin (LMWH) or unfractionated heparin (UFH) since delivery?

☐ **Yes,** please specify dose of LMWH or UFH: ☐ No

☐ Enoxaparin ________ mg ☐ Dalteparin ________ IU

☐ Tinzaparin ________ IU ☐ Nadroparin ________ IU/mg

☐ Unfractionated heparin ________ IU

Frequency of doses given: ☐ Q24H ☐ Q12H ☐ Q8H

Number of doses given since delivery: ☐ 1 ☐ 2

Date of last dose: D D M M M Y Y Y Y

Time of last dose: H H M M

4. Hospital discharge date: D D M M M Y Y Y Y

______________________________ Delegate's Name

______________________________ Delegate's Signature

D D M M M Y Y Y Y
Date