PARTUM Case Report Form Table of Contents

Instructions	
Text	Print all entries in BLOCK CAPITAL LETTERS and avoid writing outside the space provided. English should be used **and abbreviations avoided**.
Answer/ Ticking boxes	Make sure that you answer all relevant questions. Closed boxes are used for "ticking".
Blank Spaces	Please do not leave any answer fields blank. If information is unknown, please write **UNK**. If information is not applicable to this subject, please write **NA**.
Errors	Cross-out the error with a single horizontal line and write correction next to it. Make sure that the error, although crossed out, remains legible. **Initial and date each correction.**
Numeric Fields	When the answer to a question is a number, put only one digit in each box with a leading "0" when necessary.
Dates	Record the actual date of the visit. The order of the entry in the date format is day, month, year (01/JAN/2011). Day and year are to be expressed numerically; month is to be expressed textually using the first 3 letters of the month (JAN, FEB, MAR, APR, MAY and so on).
Times	The 24-hour clock time designation should be used (hours: 2 digits and minutes: 2 digits). For example, two thirty in the afternoon should be reported as 14:30 hours.

Confirmation of Eligibility: France Site

Screening No. ☐☐☐

Inclusion Criteria		YES	NO
At risk for thromboembolism for <u>ONE</u> of the following reasons:			
1.	**Known inherited thrombophilia** (diagnosed prior to enrolment) ☐ Heterozygous factor V Leiden ☐ Heterozygous prothrombin gene variant ☐ Protein C deficiency ☐ Protein S deficiency	☐	☐
2.	**Antepartum immobilization (strict bedrest) for ≥7 days at any time during pregnancy**	☐	☐
<u>OR</u> At risk for thromboembolism for any <u>TWO</u> of the following reasons:			
3.	**Pre-pregnancy BMI ≥30 kg/m^2**	☐	☐
4	**Smoking ≥5 cigarettes/day pre-pregnancy**	☐	☐
5.	**Previous clinical history of superficial vein thrombosis**	☐	☐
6.	**Pre-eclampsia** *(blood pressure ≥140 and/or 90 mmHg on at least one occasion <u>and</u> proteinuria of ≥0.3 grams/24 hours or ≥30 mg/mmol in a random urine sample)*	☐	☐
7.	**Current pregnancy ending in stillbirth** *(pregnancy loss >20 weeks gestation)*	☐	☐
8.	**Emergency cesarean delivery** *(emergency = not previously planned)*	☐	☐
9.	**Small-for-gestational-age infant at time of delivery** *(<3rd percentile adjusted for gestational age and sex)*	☐	☐
10.	**Postpartum infection** (*temperature ≥38.3°C <u>and</u> elevated WBC <u>or</u> neutrophil count <u>or</u> positive blood cultures)*	☐	☐
11.	**Postpartum hemorrhage** *(>1000 mL of blood loss, regardless of delivery mode)*	☐	☐

Exclusion Criteria		YES	NO
1.	**More than 48 hours since delivery of the placenta at the time of randomization**	☐	☐
2.	**Received more than 2 doses of LMWH since delivery of the placenta**	☐	☐
3.	**Need for postpartum LMWH prophylaxis or systemic anticoagulation as judged by the local investigator. May include but is not limited to the conditions below. If yes, please specify:** ☐ Documented history of provoked or unprovoked VTE ☐ Mechanical heart valve(s) ☐ Known antiphospholipid syndrome (APS) ☐ Known high-risk inherited thrombophilia ☐ Antithrombin deficiency ☐ Homozygous factor V Leiden ☐ Homozygous prothrombin gene mutation ☐ Compound heterozygosity factor V Leiden and prothrombin gene mutation ☐ More than 1 thrombophilia: any combination of 2 or more: factor V Leiden, prothrombin gene mutation, protein C deficiency, protein S deficiency, antithrombin deficiency ☐ Other: _____	☐	☐
4.	**Need for postpartum ASA as judged by the local investigator. May include but is not limited to:** ☐ Documented history of myocardial infarction ☐ Documented history of ischemic stroke or transient ischemic attack (TIA) ☐ Other: _____	☐	☐
5.	**History of known ASA allergy**	☐	☐
6.	**Documented history of a gastrointestinal ulcer**	☐	☐
7.	**Known platelet count <50 x 10^9/L at any time during the current pregnancy or postpartum**	☐	☐
8.	**Active bleeding at any site, excluding normal vaginal bleeding, at the time of randomization**	☐	☐
9.	**Most recent known hemoglobin ≤70 g/L documented during the current pregnancy or postpartum**	☐	☐
10.	**Known severe hypertension (SBP >200 mmHg and/or DBP >120 mmHg) during the current pregnancy or postpartum**	☐	☐
11.	**Known severe hepatic dysfunction**	☐	☐
12.	**Known severe renal dysfunction**	☐	☐
13.	**Known severe bleeding disorder/coagulopathy**	☐	☐
14.	**Known severe heart failure**	☐	☐
15.	**History of a hemorrhagic cerebrovascular accident (CVA)**	☐	☐
16.	**<18 years of age**	☐	☐
17.	**Unable to give or refused consent**	☐	☐

Eligibility Criteria		YES	NO
1.	**All eligibility criteria have been met and the subject will be enrolled into the study**	☐	☐
2.	**Version date of the consent form signed by subject:**	D D M M M Y Y Y Y	

Please review with the Investigator/Co-Investigator prior to randomization:

I _____ (Investigator/Co-Investigator) confirm that I have reviewed all relevant reports, results and annotations and find the potential subject to meet all eligibility criteria. This subject may be randomized to the pilot PARTUM trial.

_____ D D M M M Y Y Y Y

Investigator/Co-Investigator Signature Date

Randomization Case Report Form

Randomization Details	
Date of randomization:	D D M M M Y Y Y Y
☐ **Randomization code obtained and matched with study medication**	
Medication randomization code (Drug ID):					

Study Medication	
Date of subject's first dose:	D D M M M Y Y Y Y
Time of subject's first dose:	H H M M
Study medication delivered by:	_____
Study medication and booklet reviewed with the subject:	☐ Completed

_____ _____

Delegate's Name Delegate's Signature

D D M M M Y Y Y Y

Date

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:

Smoked in the last year? ☐ Yes ☐ No

Average number of cigarettes per day during pregnancy? ☐☐

Average number of cigarettes per day in the 3 months prior to pregnancy? ☐☐

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: _____
☐ Asthma ☐ Other inflammatory or autoimmune disorders(s): _____

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 <u>PRIOR pregnancies</u>?

☐ **No complications** ☐ **Yes <u>PRIOR</u> 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
- ☐ Intrauterine growth restriction or small-for gestational age
- ☐ Placental abruption
- ☐ Intrapartum infection (e.g. chorioamnionitis)
- ☐ Postpartum infection

4. Did the subject have any prior pregnancy losses?

☐ Yes ☐ No

☐	<10 weeks gestation	Number of losses: ☐☐
☐	10-20 weeks gestation	Number of losses: ☐☐
☐	>20 weeks gestation	Number of losses: ☐☐
☐	Unknown timing	Number of losses: ☐☐

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 (24 hr clock): 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: D D M M M Y Y Y Y

Time (24 hr clock): H H M M

2. Use of pneumatic compression devices, graduated compression or TED stockings since delivery (can be reported by the subject)?

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

☐ Pneumatic compression device Number of hours used: ☐☐

☐ Graduated compression stockings Number of hours used: ☐☐

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

3. Since delivery, has the subject received low-molecular-weight-heparin (LMWH) or unfractionated heparin (UFH)?

☐ **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

Concomitant Medication Form

Visit Type	Date of Visit	Delegate's Name	Delegate's Signature
☐ Baseline	D D M M M Y Y Y Y		
☐ 6-week visit	D D M M M Y Y Y Y		
☐ 90-day visit	D D M M M Y Y Y Y		
☐ Unscheduled visit	D D M M M Y Y Y Y		

NSAID Use Postpartum: ☐ Yes ☐ No

NSAID Name	Average Dose & Frequency	Date Started (dd/mmm/yyyy)	Date Stopped (dd/mmm/yyyy)	Ongoing at final visit?
				☐ Yes
				☐ Yes
				☐ Yes
				☐ Yes

PILOT PARTUM: Medication Site No. ☐☐ Subject No. ☐☐☐

Other Medication Use: ☐ Yes ☐ No Includes prescriptions, vitamins, supplements, and over the counter medications.

Medication Name	Dose & Frequency	Date Started Postpartum (dd/mmm/yyyy)	Date Stopped (dd/mmm/yyyy)	Ongoing at final visit?
				☐ Yes
				☐ Yes
				☐ Yes
				☐ Yes
				☐ Yes
				☐ Yes
				☐ Yes
				☐ Yes
				☐ Yes
				☐ Yes
				☐ Yes
				☐ Yes
				☐ Yes
				☐ Yes
				☐ Yes

6 Week Follow-up Case Report Form

A. Details of Follow-up			
1.	**Able to contact subject to complete follow-up:**	☐ Yes	☐ No
	If no, please specify reason why, and sign and date the form: ☐ Unable to contact subject after multiple attempts – see resource manual for contact procedures ☐ Subject has died (Please complete End of Study, SAE and Death Outcome Event forms) ☐ Subject withdrew consent (Please complete End of Study CRF)		
2.	**Date of follow up:** D D M M M Y Y Y Y		
3.	**Type of follow up:** ☐ In person ☐ Phone call ☐ Video call		
4.	**Study medication:** Subject's booklet collected?	☐ Yes	☐ No
	Study medication bottle collected?	☐ Yes	☐ No
	Pill count (confirmed by research team member): ☐☐		
	Number of days missed (based on subject's booklet): ☐☐		
	Number of days NSAIDs taken (based on subject's booklet): ☐☐		
	Canadian sites only: Which study medication does the subject think they received? ☐ Aspirin ☐ Placebo ☐ Unsure ☐ N/A		
	Canadian sites only: Which study medication does the research coordinator think the subject received? ☐ Aspirin ☐ Placebo ☐ Unsure ☐ N/A		
5.	**Concomitant Medication Form reviewed?**	☐ Yes	☐ No
6.	Has the subject experienced any adverse events since the last visit? **If yes, please complete Adverse Event or Serious Adverse Event Form.**	☐ Yes	☐ No
7.	Has the subject's infant experienced any adverse events since the last visit? **If yes, please complete Adverse Event or Serious Adverse Event Form.**	☐ Yes	☐ No
8a.	Is the infant receiving the subject's breastmilk (e.g. breastfeeding or pumping)?	☐ Yes	☐ No
8b.	If yes, has the infant received the subject's breastmilk on average 50% or more of the time during the last 6 weeks?	☐ Yes	☐ No
9.	Has the subject been diagnosed with a postpartum wound complication requiring a procedure?	☐ Yes	☐ No
10.	Does the subject have a diagnosed wound separation or dehiscence?	☐ Yes	☐ No
11.	Has the subject been diagnosed with a postpartum wound infection requiring antibiotics?	☐ Yes	☐ No
12.	Has the subject been diagnosed with new high blood pressure requiring medication or new protein in the urine postpartum? **If yes, please complete Postpartum Pre-eclampsia Outcome Form.**	☐ Yes	☐ No

13.	**Complete VTE Screening Form for all subjects.**	☐ Completed
14.	How long did the subject's vaginal bleeding (lochia) last for?			days ☐ Ongoing
15.	Has the subject had any bleeding since the last visit? (other than normal vaginal bleeding*) If "No" to any bleeding: probe further to confirm response by asking specifically about black stools, blood in stools, blood in urine, nose bleeds, excessive vaginal bleeding and coughing up blood. **If yes, complete Bleeding Screening Form.**	☐ Yes ☐ No
16.	Has the subject experienced a serious bruise (hematoma)?	☐ Yes ☐ No
17.	Has the subject had any chest symptoms such as shortness of breath or chest pain, or neurological symptoms such as weakness or numbness since the last visit? **If yes, complete ATE Screening Form.**	☐ Yes ☐ No

*Defined as vaginal bleeding equivalent or less in volume to subject's pre-pregnancy menstrual bleeding and blood flow does not soak through one or more sanitary pads or tampons every hour for several consecutive hours. Normal postpartum vaginal bleeding should diminish in volume and be less red in colour each day when compared to the previous day.

Delegate's Name

Delegate's Signature

D	D	M	M	M	Y	Y	Y	Y

Date

90 Day Follow-up Case Report Form

A. Details of Follow-up		
1.	**Able to contact subject to complete postpartum follow-up:** ☐ Yes ☐ No If no, please specify reason why, and sign and date the form. ☐ Unable to contact subject after multiple attempts – *see resource manual for contact procedures* ☐ Subject has died (Please complete **End of Study, SAE and Death Outcome forms**) ☐ Subject withdrew consent (Please complete **End of Study form**)
2.	**Date of follow-up:** D D M M M Y Y Y Y
3.	**Concomitant Medication Form reviewed?** ☐ Yes ☐ No
4.	Has the subject experienced any adverse events since the last visit? ☐ Yes ☐ No **If yes, please complete Adverse Event or Serious Adverse Event Form.**
5.	**Complete VTE Screening Form for all subjects.** ☐ Completed
6.	Has the subject had any bleeding since the last visit (other than normal vaginal bleeding*)? ☐ Yes ☐ No If "No" to any bleeding: probe further to confirm response by asking specifically about black stools, blood in stools, blood in urine, nose bleeds, excessive vaginal bleeding and coughing up blood. **If yes, complete Bleeding Screening Form.**
7.	Has the subject had any chest symptoms such as shortness of breath or chest pain, or neurological symptoms such as weakness or numbness since the last visit? ☐ Yes ☐ No **If yes, complete ATE Screening Form.**

* Defined as vaginal bleeding equivalent or less in volume to subject's pre-pregnancy menstrual bleeding and blood flow does not soak through one or more sanitary pads or tampons every hour for several consecutive hours. Normal postpartum vaginal bleeding should diminish in volume and be less red in colour each day when compared to the previous day.

Delegate's Name

Delegate's Signature

D D M M M Y Y Y Y
Date

Unscheduled Follow-up Visit Case Report Form

A. Details of Follow-up

1. Date of follow-up: D D M M M Y Y Y Y

2. Reason for unscheduled visit or telephone follow up:

- ☐ VTE
- ☐ Medication
- ☐ Bleeding
- ☐ Other, please specify: _____

_____

3. Concomitant Medication Form reviewed? ☐ Yes ☐ No

4. Has the subject experienced any adverse events since the last visit? ☐ Yes ☐ No
If yes, please complete Adverse Event or Serious Adverse Event Form.

5. Has the subject had any chest symptoms (shortness of breath, chest pain, hemoptysis) or leg symptoms (leg pain, redness or swelling), or any other concerns for VTE? ☐ Yes ☐ No
If yes, complete VTE Screening Form.

6. Has the subject had any bleeding since the last visit (other than normal vaginal bleeding*)? ☐ Yes ☐ No

If "No" to any bleeding: probe further to confirm response by asking specifically about black stools, blood in stools, blood in urine, nose bleeds, excessive vaginal bleeding and coughing up blood
If yes, complete Bleeding Screening Form.

7. Has the subject had any chest symptoms such as shortness of breath or chest pain, or neurological symptoms such as weakness or numbness since the last visit? ☐ Yes ☐ No
If yes, complete ATE Screening Form.

* Defined as vaginal bleeding equivalent or less in volume and length to subject's pre-pregnancy menstrual bleeding and blood flow does not soak through one or more sanitary pads or tampons every hour for several consecutive hours. Normal postpartum vaginal bleeding should diminish in volume and be less red in colour each day when compared to the previous day.

Delegate's Name _____ Delegate's Signature _____

D D M M M Y Y Y Y
Date

End of Study Case Report Form

A. Study Completion

1. Date of study termination: D D M M M Y Y Y Y

2. Reason for study termination:

- ☐ Routine study termination, study protocol completed
- ☐ Early study termination, due to:
  - ☐ Lost to follow up
  - ☐ Death*
  - ☐ Withdrawal of subject's consent**:
    - ☐ Subject allows data collection to continue
    - ☐ Subject refuses further data collection
  - ☐ Other, please specify:_____

***If selected, please complete Death Outcome Form and SAE form**

****Reason(s) subject has withdrawn consent:**

B. Suspected Secondary Outcome Events

1. Did the subject have one or more suspected outcome events listed below that will undergo adjudication? (check all that apply)*:

☐ **None**	☐ Symptomatic venous thromboembolism	☐ Bleeding/Hematoma
☐ Death*	☐ Symptomatic arterial thromboembolism	☐ Postpartum pre-eclampsia

***If yes, please ensure corresponding Outcome Event and SAE form(s) are completed.**

Delegate's Name:
Signature:
I have reviewed all entries on the Case Report Forms. All information entered onto the Case Report Form for this subject is, to the best of my knowledge, correct.
Investigator's Name:
Signature:
Date: D D M M M Y Y Y Y

Follow-up Screening: VTE

VTE Screening

1. Follow-Up Visit / Phone or Video Call:

☐ 6 weeks (Visit/call) ☐ 90 days (Call) ☐ Unscheduled (Visit/Call)

2. Follow-Up Date: D D M M M Y Y Y Y

Instructions: Use the following categories to rate each symptom. Choose the one best answer.
None: Patient is not experiencing this symptom today.
New: Patient has this symptom today, but did not have it at her last study visit.
Worse: Patient had this symptom at her last study visit and it has gotten worse.
Same: Patient had this symptom at her last study visit and it has not changed.

3. Deep Vein Thrombosis (DVT) Symptoms:	None	New	Worse	Same
Pain in limb(s): ☐ L leg ☐ R leg ☐ L arm ☐ R arm	☐	☐	☐	☐
Swelling in limb(s): ☐ L leg ☐ R leg ☐ L arm ☐ R arm	☐	☐	☐	☐
Tenderness of the leg(s): • Along the path of the deep vein (groin, thigh, behind the knee and/or in the deep calf) ☐ L leg ☐ R leg	☐	☐	☐	☐
Tenderness of the arm(s): • In the armpit, under the clavicle and/or in the neck ☐ L arm ☐ R arm	☐	☐	☐	☐
Warmth in the limb(s): ☐ L leg ☐ R leg ☐ L arm ☐ R arm	☐	☐	☐	☐
Redness or purple discoloration of the skin in the limb(s): ☐ L leg ☐ R leg ☐ L arm ☐ R arm	☐	☐	☐	☐

4. Pulmonary Embolism (PE) Symptoms:	None	New	Worse	Same
Shortness of breath	☐	☐	☐	☐
Pain in the chest	☐	☐	☐	☐
Rapid pulse or racing heart	☐	☐	☐	☐
Cough with blood in sputum	☐	☐	☐	☐
Fainting or near fainting episodes	☐	☐	☐	☐

If the subject responds 'New' or 'Worse to any chest symptoms, complete the ATE Screening Form.

Important: Any NEW or WORSE leg or chest symptoms will prompt response of study personnel to collect all pertinent source documents to diagnose or exclude VTE as indicated in the Protocol, including arranging for patient assessment if required.

Follow-up Screening: ATE

ATE Screening				
1. Follow-Up Visit / Phone or Video Call: ☐ 6 weeks (Visit/Call) ☐ 90 days (Call) ☐ Unscheduled (Visit/Call)				
2. Follow-Up Date: D D M M M Y Y Y Y				
Instructions: Use the following categories to rate each symptom. Choose the one best answer. **None:** Patient is not experiencing this symptom today. **New:** Patient has this symptom today, but did not have it at her last study visit. **Worse:** Patient had this symptom at her last study visit and it has gotten worse. **Same:** Patient had this symptom at her last study visit and it has not changed.				
3. Myocardial Infarction Symptoms:	None	New	Worse	Same
Pressure, tightness or pain in chest ☐ Arm or jaw radiation	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐
Nausea or vomiting	☐	☐	☐	☐
Cold sweat (Diaphoresis)	☐	☐	☐	☐
Fainting or near fainting episodes	☐	☐	☐	☐
4. Stroke / TIA Symptoms:	None	New	Worse	Same
Weakness of the face, arms or legs	☐	☐	☐	☐
Numbness or tingling to the face, arms or legs	☐	☐	☐	☐
Slurred speech, trouble speaking or understanding speech	☐	☐	☐	☐
Sudden vision loss	☐	☐	☐	☐
Sudden loss of balance or coordination	☐	☐	☐	☐

Important: Any NEW or WORSE chest symptoms or neurological symptoms will prompt response of study personnel to collect all pertinent source documents to diagnose or exclude ATE as indicated in the Protocol, including arranging for patient assessment if required.

Follow-up Screening: Bleeding

Expected postpartum vaginal bleeding (lochia) is not included.

Bleeding Screening
1. Follow-Up Visit/ Phone or Video Call: ☐ 6 weeks (Visit/Call) ☐ 90 days (Call) ☐ Unscheduled (Visit/Call)
2. Follow-Up Date: D D M M M Y Y Y Y
Instructions: Complete the following interview script for bleeding events. **Expected postpartum vaginal bleeding (lochia) is not included as a bleeding event.** Normal postpartum vaginal bleeding should diminish in volume and be less red in colour each day when compared to the previous day.
3. Bleeding:
1. Did you seek any medical attention for bleeding since the last study visit? ☐ Yes* ☐ No If yes, specify why? _____ Where / from whom was medical attention given? _____
2. Were you hospitalized for bleeding since the last study visit? ☐ Yes* ☐ No If yes, specify why? _____ Where were you hospitalized? _____
3. Have you had any bleeding since the last study visit? ☐ Yes ☐ No
3.3a. Where was the bleeding, specify location(s)? _____
3.3b. Was it external (i.e., you saw the blood)? ☐ Yes ☐ No
3.3c. Did the bleeding last longer than 10 minutes? ☐ Yes* ☐ No *Indicate date and time bleeding started: D D M M M Y Y Y Y H H M M *Indicate date and time bleeding stopped: D D M M M Y Y Y Y H H M M
3.3d. Did the bleed stop on its own? ☐ Yes ☐ No
3.3e. Did the bleeding cause discomfort or pain? ☐ Yes ☐ No
3.3f. Did the bleeding have an effect on your usual daily activities? ☐ Yes ☐ No If yes, specify why? _____
3.3g. Were you taking the study drug when the bleeding started? ☐ Yes ☐ No
3.3h. Description of bleeding event (describe all relevant information/events preceding and at the time of the bleed):

Important: If MEDICAL ATTENTION was sought or patient was hospitalized, then study personnel will collect all pertinent source documents to diagnose or exclude bleeding as indicated in the Protocol, including arranging for patient assessment if required.

Protocol Deviation / Violation Form

Type of Event	
☐	**Protocol Deviation:** non-compliance with the protocol that is unlikely to have a significant impact on the patient's rights, safety and welfare, or on the integrity of the data.
☐	**Protocol Violation:** non-compliance with the protocol that may have a significant impact on the patient's rights, safety and welfare, or on the integrity of the data and can cause the coordinating centre to exclude the patient from the eligibility analysis and/or discontinue the patient from the study.

Protocol Deviation / Violation / Unanticipated Risk Involving Participant (UaP)

Date of deviation or violation: D D M M M Y Y Y Y

Categories:

- ☐ Informed consent process error
- ☐ Participant did not meet Inclusion/Exclusion Criteria
- ☐ Randomization error
- ☐ Study visit
  - ☐ Incomplete visit
  - ☐ Outside of study window
  - ☐ Missed visit
- ☐ Study booklet
  - ☐ Incomplete study booklet
  - ☐ Failed to return study booklet
- ☐ Study medication
  - ☐ Dispensing error
  - ☐ Dosing error
  - ☐ Use of prohibited medication
  - ☐ Stopped medication early
  - ☐ Failed to return study medication
- ☐ Improper breaking of the blind
- ☐ Unreported SAE
- ☐ Other: _____

Event description:
Please provide details of the deviation or violation. Include any other relevant information not captured elsewhere on the form.

Actions taken to reconcile the deviation or violation and prevent future occurrences:

Protocol Violations ONLY Please complete this section only if the non-compliance is a violation.	
Did the violation impact subject's rights and/or safety?	☐ **Yes** ☐ **No**

Reporting Centre
Delegate's Name:
Signature:
Investigator's Name:
Signature:
Date: D D M M M Y Y Y Y

Adverse Event Form

If the AE meets the definition of a SAE, please complete a Serious Adverse Event Form.
(Do not complete this form)

Timeline of Adverse Event	
AE report date:	D D M M M Y Y Y Y
AE start date:	D D M M M Y Y Y Y
AE end date: ☐ Ongoing	D D M M M Y Y Y Y

Adverse Event Information		
Participant or infant?	☐ Participant	☐ Infant
Condition/Diagnosis:		
AE Term (MedDRA Coding):		
Event Description: Include a history of the event chronologically including signs and characteristics, severity, dates and outcomes and any other relevant information not captured elsewhere on the form. Include relevant tests/data, treatment/procedures, medical history, treatment history.		
Action taken with study medication: ☐ No change ☐ Other medication(s) started for AE: _____	☐ Study medication temporarily discontinued ☐ Study medication permanently discontinued ☐ Other, please specify: _____	
Clinical outcome: ☐ Recovered/resolved ☐ Not yet recovered ☐ Unknown	☐ Recovered with sequelae ☐ Study medication discontinued	

This section to be completed by the Investigator only		
Severity/Intensity		
☐ **Mild**	☐ **Moderate**	☐ **Severe**
Causality		
☐ **Unrelated**	☐ **Possibly related**	☐ **Related**
Expectedness		
☐ **Expected/Anticipated**	☐ **Unexpected/Unanticipated**	
Gravity		
☐ **Non-serious**	☐ **Serious***	

*If the AE meets the definition of an SAE, complete the SAE form instead

Reporting Centre	
Delegate's Name:	
Signature:	
Investigator's Name:	
Signature:	
Date:	D D M M M Y Y Y Y

Serious Adverse Event Form

Complete one form for each SAE. Submit all supporting source documents (with no identifying information). The source documents must be signed and dated by the investigator.

SAE report type		
☐ **Initial**	☐ **Follow-up**	☐ **Final**
Participant or infant?	☐ Participant	☐ Infant
SAE report date:	D D M M M Y Y Y Y	
Condition/Diagnosis:		
SAE Term (MedDRA Coding):		
Event Description: Include a history of the event chronologically including signs and characteristics, severity, dates and outcomes of hospitalization and any other relevant information not captured elsewhere on the form. Include relevant tests/data, treatment/procedures, medical history, treatment history.		

Serious Adverse Event Information		
Date of onset:	D D M M M Y Y Y Y	
Date when event became serious:	D D M M M Y Y Y Y	
Date SAE ended:	☐ Ongoing	D D M M M Y Y Y Y
SAE category:		
☐ Death	☐ Persistent or significant disability/incapacity	
☐ Life-threatening	☐ Other medically relevant condition judged or defined as serious	
☐ Other, please specify:	☐ New or prolonged hospitalization	
_____		
**As per the Protocol, congenital anomalies or birth defects will not be reported as an SAE*		

SAE status/clinical outcome:

- ☐ Death
- ☐ Not yet recovered
- ☐ Recovered with sequelae
- ☐ Recovered/Resolved
- ☐ Unknown

Relevant Information to SAE

Have relevant source documents been attached? ☐ Yes ☐ No

Study Medication

Date of first dose: D D M M M Y Y Y Y

Date of last dose prior to SAE: D D M M M Y Y Y Y

Action taken with study medication:

- ☐ No change
- ☐ Study medication temporarily discontinued
- ☐ Study medication permanently discontinued
- ☐ Other medication(s) started for AE/SAE: _____
- ☐ Other, please specify: _____

If the study medication was temporarily or permanently discontinued:

Study medication stopped on: D D M M M Y Y Y Y ☐ N/A

Study medication restarted on: D D M M M Y Y Y Y ☐ N/A

Did the event resolve after study medication stopped? ☐ Yes ☐ No ☐ N/A

Did event reappear after reintroducing study medication? ☐ Yes ☐ No ☐ N/A

Concomitant medications: Source documents have been attached? (Exclude those used to treat reaction) ☐ Yes ☐ No

This section to be completed by the Investigator only		
Severity/Intensity		
☐ Mild	☐ Moderate	☐ Severe
Causality		
☐ Unrelated	☐ Possibly related	☐ Related
Expectedness		
☐ Expected/Anticipated	☐ Unexpected/Unanticipated	
Gravity		
☐ Non-serious	☐ Serious	
Possible causes of the event (check all that apply):		
☐ Pre-existing/Underlying disease: _____		
☐ Study treatment: _____		
☐ Other treatment: _____		
☐ Other (e.g. accident, new or intercurrent illness): _____		

Reporting Centre	
Delegate's Name	
Delegate's Signature	
Investigator's Name:	
Signature:	
Date:	D D M M M Y Y Y Y

Coordinating Trial Centre	
Principal Investigator:	
Signature:	
Date:	D D M M M Y Y Y Y

In the occurrence of an SAE, the Sponsor is to be notified within 24 hours of awareness of the event. The SAE CRF should be uploaded via the secure REDCap cloud electronic data management system along with all de-identified source documents, with an email to laskeith@ucalgary.ca and alexandra.garven@ucalgary.ca to confirm receipt of the SAE electronic CRF.