uktis
uk teratology information service

PRIVATE & CONFIDENTIAL

Public Health England

Drug and chemical exposure in pregnancy: Website reporting form for completed pregnancies

Please complete this form and return it to the UK Teratology Information Service using the FREEPOST address below or by fax to 0191 261 8839. Alternatively please send a copy of the handheld maternal notes and we will extract the appropriate information. NO advice will be provided by UKTIS when submitting this form. Please telephone the enquiry line on 0344 892 0909 for a patient specific risk assessment/advice.

PLEASE ENCLOSE COPIES OF ANY RELEVANT MEDICAL REPORTS OR CORRESPONDENCE

UKTIS FREEPOST address: UK Teratology Information Service, Regional Drug & Therapeutics Centre, FREEPOST NEA1573, Newcastle upon Tyne, NE2 1BR (no stamp required).

Date_____/_____/_____

PATIENT'S DETAILS

Name …….. Date of birth ……

NHS number ……Hospital number……..

Address……

Postcode……

Telephone number……..

Occupation……..

Ethnic group …… (Please use codes provided in box)

Smoker? never ☐ gave up prior to pregnancy ☐
gave up during pregnancy ☐ current ☐

Units of alcohol per week (during pregnancy)? ……units

Illicit/recreational drugs (during pregnancy)? Yes ☐ No ☐ Don't know ☐

If **yes**, please provide details ……

UK census coding for ethnic group

WHITE
- 01British
- 02 Irish
- 03 Any other white background

MIXED
- 04 White and black Caribbean
- 05 White and black African
- 06 White and Asian
- 07 Any other mixed background

ASIAN OR ASIAN BRITISH
- 08 Indian
- 09 Pakistani
- 10 Bangladeshi
- 11 Any other Asian background

BLACK OR BLACK BRITISH
- 12 Caribbean
- 13 African
- 14.Any other black background

CHINESE OR OTHER ETHNIC GROUP
- 15 Chinese
- 16 Any other ethnic group

PREGNANCY DETAILS

LMP _____/_____/_____ EDD _____/_____/_____

Height at booking _____cm Weight at booking _____kg

Did the patient take folic acid preconceptually? Yes ☐ No ☐ Don't know ☐

Is the patient currently taking folic acid during pregnancy? Yes ☐ No ☐ Don't know ☐

If yes, date commenced _____/_____/_____ Dose (if known)……

The data protection aspects of this surveillance activity are covered by Section 251 of the NHS Act 2006, but health professionals are asked, where possible, to ensure that the women involved are aware that their personal information is being reviewed in this way and that they are happy for it to be held for this purpose. Please see our website www.uktis.org for further details.

Patient's name…… Date of birth _____/_____/_____

Have there been any pregnancy complications or acute illness? Yes ☐ No ☐ Don't know ☐

If **yes**, please provide details below, including the stage of pregnancy at which these occurred

……

……

Please provide details of any abnormalities on antenatal screening (including blood tests and ultrasound scans)

……

……

MEDICATION IN PREGANCY

Has the patient taken any prescribed medications, alternative medicines, OTC preparations or, were drugs used in labour during her current pregnancy? Yes ☐ No ☐ Don't know ☐

If **yes**, please provide details in the table below.
*If the patient is still pregnant and the exposure is on-going please state 'on-going'

NAME OF MEDICATION TAKEN IN PREGNANCY	DOSE	SCHEDULE E.G. TDS	ROUTE	DATE/GESTATION STARTED	DATE/GESTATION STOPPED*

Were any of the drugs taken in overdose? Yes ☐ No ☐ Don't know ☐

If **yes**, was the overdose: Accidental ☐ Intentional ☐ Don't know ☐

Was there any maternal toxicity/symptoms? Yes ☐ No ☐ Don't know ☐

If **yes**, please detail……

Any maternal treatment? ……

Maternal test results? ……..

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Patient name…… Date of birth _____/_____/_____

CHEMICAL EXPOSURE IN PREGNANCY

Has the patient been exposed to any chemicals during her current pregnancy? Yes ☐ No ☐ Don't know ☐
*If **yes**, please provide details in the table below*

NAME OF CHEMICAL	DOSE/LEVEL	ROUTE	FREQUENCY I.E. NO. OF HOURS PER DAY & NO. OF DAYS PER WEEK	DATE/GESTATION EXPOSURE OCCURRED	DATE/GESTATION EXPOSURE CEASED

In the case of chemical/poisoning was there any maternal toxicity/symptoms? Yes ☐ No ☐ Don't know ☐

If **yes**, please detail…….

Maternal treatment? ……..……

Maternal test results? ……..

Any additional information of relevance – past medical history, obstetric history, and family history of congenital malformations or adverse outcomes

……..

…….

Please provide details of any abnormalities on antenatal screening (including ultrasound)

……

What was the pregnancy outcome? Please tick one and indicate the gestational age)

☐Live born @ …./40 weeks ☐Elective termination* @ …./40 weeks ☐Neonatal death @ …..days

☐Miscarriage @..../40 weeks ☐Intrauterine death @..../40 weeks

Date of delivery ……/…../….. Date of neonatal death ……/……/……

Details of delivery (e.g. induced) ……

……..

For elective termination please indicate the reason:
☐ Concerns re. effects of medication/chemical exposure ☐Personal
☐Abnormalities on scan or prenatal screening ☐Other (please provide details)…….

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Patient name…… Date of birth _____/_____/_____

Please complete the following about the baby:

Baby's name …… Gender: Male☐ Female☐ Intermediate☐

Baby's NHS number ……..

Weight: _____ g Length: _____ cm Head circumference: _____ cm

APGAR 5 minutes: _____ APGAR 10 minutes_____

Were there any **congenital malformations**? Yes☐ No☐ Don't know ☐

If Yes, please give as many details as possible ……...

……

Were there any **neonatal problems** affecting the child? Yes☐ No☐ Don't know ☐

Was the infant admitted to a neonatal unit? Yes☐ No☐ Don't know ☐

If Yes to either question, please give as many details as possible ……...

……

……

Please use this space to enter any other information you feel may be important:

……..

……

……

GENERAL PRACTITIONER OR MIDWIFE NAME AND ADDRESS:

……...

……...

YOUR DETAILS:

Profession …… Name ……..……..

Address …… ……

……..…

☎ …… FAX ……

Please copy us into any further correspondence regarding this pregnancy/child.
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