





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? .....

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<br>I.E. NO. OF<br>HOURS PER<br>DAY & NO.<br>OF DAYS<br>PER WEEK | DATE/GESTATION<br>EXPOSURE<br>OCCURRED | DATE/GESTATION<br>EXPOSURE<br>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

GENERAL PRACTITIONER/MIDWIFE NAME AND ADDRESS:

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](http://www.uktis.org) for further details.

**YOUR DETAILS:**

Profession ..... Name


.....

Address .....

.....

.....

.....

 ..... FAX .....

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

**Thank you for completing this form - please return to UKTIS using the FREEPOST address or by fax to: 0191 261 8839**

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