AMOSS Case ID _____

Case Report Form

RENAL DISEASE IN PREGNANCY

Details about the person filling in this form

Name of person completing the form _____
Work phone number _____
Professional group

Midwife	☐
Obstetrician	☐
Obstetric physician	☐
Maternal-fetal specialist	☐
AMOSS study coordinator	☐
Health information manager/Quality assurance officer	☐
Anaesthetist	☐
Renal physician	☐
Renal nurse	☐
Physician/District Medical Officer (DMO)	☐
RMO/Registrar	☐
GP / GP with Obstetric Diploma	☐
Remote area nurse (RAN)	☐
Registered Nurse (other)	☐
Other – please specify	☐ _____

Date data form was completed ☐☐/☐☐/☐☐

Has the Medical Record Number (MRN) been recorded against the AMOSS Case ID in the Log Sheet?
Yes ☐ No ☐ (*If no, please do so now. This is to help you easily identify the patient, if AMOSS has any questions about this case in the future.)*

Inclusion criteria

All women in Australia who present with advanced chronic kidney disease or severe acute kidney injury before or during pregnancy.

Reporting guidelines
Inclusion:
If the woman has any of the following:

1. A working kidney transplant (all women regardless of kidney transplant function) Yes ☐ No ☐
2. Receiving any long-term dialysis before conception and continuing any dialysis during this pregnancy Yes ☐ No ☐
3. Started any dialysis during this pregnancy (any dialysis - either once off, temporary or permanent dialysis) Yes ☐ No ☐
4. Known pre-conception eGFR <45ml/min/1.73m2 (known to have a serum creatinine >130-150 µmol/L BEFORE conception, regardless of the serum creatinine reading during pregnancy; eGFR is reported along with serum creatinine in the biochemistry report) Yes ☐ No ☐
5. Newly identified kidney impairment with any serum creatinine reading of >150 µmol/L on 2 readings at least 24 hours apart during this pregnancy Yes ☐ No ☐

Please contact AMOSS amoss@uts.edu.au or 02 9514 8041 with any queries about inclusion.

SECTION 1: GENERAL RENAL HISTORY

1. **Did this woman receive care in a maternity service co-located with a renal service?**
Yes ☐ No ☐ Not known ☐

1.1. *(If yes)* Was the primary case medical record shared between these services?
Yes ☐ No ☐ Not known ☐

2. **Renal History Prior to Pregnancy** *(where more than one criterion applies, choose all that apply)*

2.1. **Functioning kidney transplant** Yes ☐ No ☐

2.2. **Chronic maintenance dialysis** Yes ☐ No ☐

2.3. **Known kidney impairment or kidney disease before this pregnancy** Yes ☐ No ☐

2.4. **No known renal history – kidney impairment was diagnosed for the first time during this pregnancy** Yes ☐ No ☐

3. **Underlying cause or condition causing kidney disease in this woman** *(choose all that apply)*

3.1. **Glomerulonephritis** Yes ☐ No ☐

(If yes)
- Lupus nephritis Yes ☐ No ☐
- IgA nephropathy Yes ☐ No ☐
- Vasculitis Yes ☐ No ☐
- Minimal change disease Yes ☐ No ☐
- Focal Segmental Glomerulosclerosis Yes ☐ No ☐
- Membranous nephritis Yes ☐ No ☐
- Anti-GBM disease Yes ☐ No ☐
- Other glomerulonephritis Yes ☐ No ☐
  (If yes) specify _____

3.2. **Reflux nephropathy** Yes ☐ No ☐

3.3. **Genetic disease** Yes ☐ No ☐

(If yes)
- Hereditary nephritis (Alport's disease or other) Yes ☐ No ☐
- Polycystic kidney disease Yes ☐ No ☐
- Other genetic disease Yes ☐ No ☐
  (If yes) specify _____

3.4. **Congenital renal disease** *(e.g.congenital renal obstruction, congenital malformation, obstructive uropathy)* Yes ☐ No ☐

3.5. **Diabetic nephropathy** Yes ☐ No ☐

3.6. **Hypertension** Yes ☐ No ☐

3.7. **Kidney stones** Yes ☐ No ☐

3.8. **Interstitial nephritis** Yes ☐ No ☐

3.9. **Obstetric complications during this pregnancy** Yes ☐ No ☐

(If yes)
- Preeclampsia Yes ☐ No ☐
- Placental abruption Yes ☐ No ☐
- Hyperemesis gravidarum Yes ☐ No ☐
- Ovarian hyperstimulation syndrome (OHSS) Yes ☐ No ☐
- Amniotic fluid embolism Yes ☐ No ☐
- Other Obstetric complications Yes ☐ No ☐
  (If yes) specify _____

3.10. **Haemolytic uraemic syndrome** Yes ☐ No ☐

3.11. **Cortical necrosis** Yes ☐ No ☐

3.12. **Acute fatty liver of pregnancy** Yes ☐ No ☐

SECTION 1

3.13. **Sepsis** *(Renal sepsis, Non-renal sepsis, septic shock)* Yes ☐ No ☐
(If yes) Renal sepsis (inc pyelonephritis, TB, abscess) Yes ☐ No ☐
Non-renal sepsis (including abortion) Yes ☐ No ☐
Sepsis causing septic shock Yes ☐ No ☐
Cause of sepsis _____

3.14. **Blood loss** Yes ☐ No ☐
(*If yes)* choose all that apply
Antepartum haemorrhage Yes ☐ No ☐
Post-partum haemorrhage Yes ☐ No ☐
Gastrointestinal bleed Yes ☐ No ☐
Trauma Yes ☐ No ☐
Other Yes ☐ No ☐
(If yes) specify _____

3.15. **Fluid losses** Yes ☐ No ☐
(*If yes)* choose all that apply
Vomiting or diarrhoea Yes ☐ No ☐
Polyuria Yes ☐ No ☐
Nasogastric losses Yes ☐ No ☐
Other Yes ☐ No ☐
(*If yes)* specify _____

3.16. **Poor fluid intake causing dehydration** Yes ☐ No ☐
3.17. **Cardiac event** Yes ☐ No ☐
(*If yes)* choose all that apply
Myocardial infarction Yes ☐ No ☐
Heart failure Yes ☐ No ☐
Other cardiac event Yes ☐ No ☐
(If yes) specify _____
3.18. **Nephrotoxic drugs** Yes ☐ No ☐
(If yes) specify _____
3.19. **Mechanical obstruction of ureters or bladder** Yes ☐ No ☐
3.20. **Other** Yes ☐ No ☐
(If yes) specify _____
3.21. **Underlying cause is not known (at time of survey completion)** Yes ☐ No ☐

4. **Did this woman have any kidney problems associated with previous pregnancies?**
Yes ☐ No ☐ Not known ☐ Not applicable ☐
4.1. *(If yes)* Chronic kidney disease Yes ☐ No ☐ Not known ☐
4.2. Dialysis Yes ☐ No ☐ Not known ☐
4.3. Transplant Yes ☐ No ☐ Not known ☐
4.4. Acute kidney failure Yes ☐ No ☐ Not known ☐

5. **Did this woman have a natural/native kidney biopsy PRIOR to this pregnancy?**
Yes ☐ No ☐ Not known ☐
(*If yes)* please attach non identifiable reports

6. **Did this woman have a natural/native kidney biopsy DURING this pregnancy?**
Yes ☐ No ☐ Not known ☐
(*If yes)* please attach non identifiable reports

SECTION 1

7. **Has this woman been reviewed in a Renal Unit or by a Renal Physician?**
Yes ☐ No ☐ Not known ☐

7.1. *(If yes)* Reviewed prior to this pregnancy? Yes ☐ No ☐ Not known ☐

7.2. Reviewed during this pregnancy? Yes ☐ No ☐ Not known ☐

(If yes) Gestation of first nephrologist review (weeks) _____
Date of review: ___/___/_____
Reviewed in a high risk pregnancy clinic Yes ☐ No ☐ Not known ☐
Reviewed in a general renal clinic Yes ☐ No ☐ Not known ☐

8. **Where was the kidney condition primarily managed?** *(select one)*
☐ Adult obstetric HDU/ICU
☐ Adult non-obstetric HDU/ICU
☐ Renal Unit
☐ General Maternity Ward
☐ Emergency Department
☐ Other
(If other) specify _____

9. **Was this woman transferred to another hospital at any time?**
Yes ☐ No ☐ Not known ☐
(*If yes)*

9.1. To access renal services Yes ☐ No ☐ Not known ☐
9.2. To access adult ICU Yes ☐ No ☐ Not known ☐
9.3. To access neonatal ICU Yes ☐ No ☐ Not known ☐

10. **Management of kidney problem *(choose all that apply)***

10.1. Oral Fluid therapy Yes ☐ No ☐ Not known ☐
10.2. Intravenous Fluid therapy Yes ☐ No ☐ Not known ☐
10.3. Inotropic support Yes ☐ No ☐ Not known ☐
10.4. Dialysis (complete dialysis section) Yes ☐ No ☐ Not known ☐
10.5. Antibiotics for sepsis Yes ☐ No ☐ Not known ☐
10.6. Blood transfusion Yes ☐ No ☐ Not known ☐
10.7. Immunosuppressive therapy Yes ☐ No ☐ Not known ☐
(If yes) specify _____

10.8. Plasma exchange Yes ☐ No ☐ Not known ☐
10.9. Eculizumab (for atypical Haemolytic uraemic syndrome) Yes ☐ No ☐ Not known ☐
10.10. Urinary catheterisation Yes ☐ No ☐ Not known ☐
10.11. Other measures to relieve urinary tract obstruction (e.g nephrostomy, stone retrieval) Yes ☐ No ☐ Not known ☐
10.12. Diuretic therapy Yes ☐ No ☐ Not known ☐
10.13. Treatment of hyperkalaemia Yes ☐ No ☐ Not known ☐
(If yes) Dialysis for hyperkalaemia Yes ☐ No ☐ Not known ☐
10.14. Other treatments Yes ☐ No ☐ Not known ☐
(If yes) specify _____

11. RENAL PARAMETER READINGS IN THIS PREGNANCY – HIGHEST VALUE (except haemoglobin)***

	PRE-PREGNANCY		AT BOOKING		1ST TRIMESTER		2ND TRIMESTER	
	Value	*Date*	*Value*	*Date*	*Value*	*Date*	*Value*	*Date*
Serum Creatinine (µmol/L)								
Estimated GFR								
Serum Urea (mmol/L)								
Serum potassium (mmol/L)								
Serum phosphate (mmol/L)								
Serum uric acid (µmol/L)								
Haemoglobin (lowest)* (g/L)								
Urine Protein (P:Cr) (mg/mmol)								
Urine Protein (24 hour) (g/24hr)								
Urine A:Cr (mg/mmol)								

	3RD TRIMESTER		AT DELIVERY		AT DISCHARGE	
	Value	*Date*	*Value*	*Date*	*Value*	*Date*
Serum Creatinine (µmol/L)						
Estimated GFR						
Serum Urea (mmol/L)						
Serum potassium (mmol/L)						
Serum phosphate (mmol/L)						
Serum uric acid (µmol/L)						
Haemoglobin (lowest)* (g/L)						
Urine Protein (P:Cr) (mg/mmol)						
Urine Protein (24 hour) (g/24hr)						
Urine A:Cr (mg/mmol)						

12. Was this woman admitted to hospital during this pregnancy (other than for delivery)?
Yes ☐ No ☐ Not known ☐
If yes
State admission and discharge dates, reason, and treatment given.

Date admitted _____ Date discharged _____
Reason _____
_____
Treatment _____
_____
_____
_____

SECTION 2: TRANSPLANT HISTORY

1. **Did this woman have a functioning kidney transplant at conception?**
Yes ☐ No ☐ Not known ☐ ***IF NO, SKIP TO SECTION 3***

(If yes) **Date of current transplant** ___/___/_____

Transplant source (current transplant) *(choose one)* ☐ Living donor
☐ Deceased donor
☐ Not known

1.1. **Has this woman had more than one kidney transplant?** Yes ☐ No ☐ Not known ☐
(If yes) Total number of kidney transplants _____

1.2. **Has this woman had a non-kidney transplant?**
Yes ☐ No ☐ Not known ☐

(If yes)

Pancreas — Yes ☐ No ☐ Not known ☐
Date ___/___/_____

Liver — Yes ☐ No ☐ Not known ☐
Date ___/___/_____

Other — Yes ☐ No ☐ Not known ☐
Date ___/___/_____
Other transplant *(specify)* _____

2. **Has this woman had a transplant kidney biopsy in the 12 months PRIOR to this pregnancy?**
Yes ☐ No ☐ Not known ☐
(If yes) attach deidentified reports

3. **Did this woman have a transplant kidney biopsy DURING this pregnancy?**
Yes ☐ No ☐ Not known ☐
(If yes) attach deidentified reports

4. **Was there treatment for transplant rejection in this pregnancy?**
Yes ☐ No ☐ Not known ☐
(If yes) How was rejection treated?

4.1.	Increased dose of existing immunosuppression	Yes ☐ No ☐ Not known ☐
4.2.	Intravenous methylprednisolone	Yes ☐ No ☐ Not known ☐
4.3.	T-cell depletion therapy (drugs such as ATG or OKT3)	Yes ☐ No ☐ Not known ☐
4.4.	Plasma exchange	Yes ☐ No ☐ Not known ☐
4.5.	Photopheresis	Yes ☐ No ☐ Not known ☐
4.6.	Other therapy	Yes ☐ No ☐ Not known ☐

Other *(specify)* _____

SECTION 3: DIALYSIS IN THIS PREGNANCY

1. Did this woman receive ANY dialysis during this pregnancy?
Yes ☐ No ☐ Not known ☐ ***IF NO, SKIP TO SECTION 4***

(If yes) **please contact the AMOSS team if you need assistance**

2. COMMENCEMENT OF DIALYSIS IN THIS PREGNANCY (women not previously receiving dialysis)

2.1. Did this woman commence dialysis therapy FOR THE FIRST TIME DURING this pregnancy?
Yes ☐ No ☐ Not known ☐

IF NO, SKIP TO QUESTION 3
(If not known), ***please contact the AMOSS team for assistance***

(If yes) please answer questions below

2.2. Reason for commencing dialysis therapy (choose all that apply)

Newly diagnosed significant kidney dysfunction	Yes ☐ No ☐ Not known ☐
Pre-existing kidney disease / impairment that became worse during pregnancy	Yes ☐ No ☐ Not known ☐
Uncontrolled hypertension	Yes ☐ No ☐ Not known ☐
Poor fetal growth	Yes ☐ No ☐ Not known ☐
Fluid overload	Yes ☐ No ☐ Not known ☐
Pre-eclampsia	Yes ☐ No ☐ Not known ☐
High potassium	Yes ☐ No ☐ Not known ☐
Acidosis	Yes ☐ No ☐ Not known ☐
Uraemic symptoms (nausea, vomiting, itching)	Yes ☐ No ☐ Not known ☐
Other	Yes ☐ No ☐ Not known ☐

(If yes) specify _____

2.3. First Haemodialysis This Pregnancy – Treatment Details

What date did dialysis start? ____/____/_____
Dialysis duration (hours) _____
Type of dialysis *(choose one)*
- ☐ Intermittent
- ☐ Continuous

Heparin or citrate anticoagulation Yes ☐ No ☐ Not known ☐
Pre-dialysis creatinine _____ (µmol/L)
Pre-dialysis urea _____ (mmol/L)
Pre-dialysis phosphate _____ (mmol/L)
Pre-dialysis potassium _____ (mmol/L)
Pre-dialysis weight _____ (kg)
Site of first dialysis treatment *(choose one)*
- ☐ ICU
- ☐ Ward
- ☐ Outpatient Dialysis Unit

If this woman initially received continuous dialysis (in intensive care), was this later changed to intermittent dialysis? Yes ☐ No ☐ Not known ☐
(If yes)
Date of first intermittent dialysis ____/____/_____
Total number of intermittent dialysis treatments _____

Date of last dialysis treatment (if dialysis ceased before discharge)? ____/____/_____

Did this woman continue to have ongoing dialysis after discharge (or a plan for further dialysis)?
Yes ☐ No ☐ Not known ☐

Did this woman remain on dialysis permanently? Yes ☐ No ☐ Not known ☐
What date did dialysis eventually cease (if known)? ____/____/_____

2.4. Monitoring received during first dialysis treatment *(select all that apply)*

Fetal CTG	Yes ☐ No ☐ Not known ☐
Dopplers	Yes ☐ No ☐ Not known ☐
Maternal cardiac monitoring	Yes ☐ No ☐ Not known ☐
Other monitoring	Yes ☐ No ☐ Not known ☐

(If yes) specify _____

3. CHRONIC/ONGOING DIALYSIS

3.1. Date of commencing chronic maintenance dialysis *(pre-conception)* ____/ _____ / _____

3.2. Last pre-conception dialysis modality *(choose one)*
☐ peritoneal dialysis (PD)
☐ haemodialysis

3.3. Total hours of dialysis per week *(pre-conception)* _____

3.4. Change of dialysis modality during pregnancy?
Yes ☐ No ☐ Not known ☐
(If yes) choose one
☐ Haemodialysis changed to peritoneal dialysis
☐ Peritoneal dialysis changed to haemodialysis
Date of change of modality ____/___/_____
Reason for change of modality _____

3.5. Dialysis modality DURING this pregnancy *(choose one)*

☐ haemodialysis ***IF YES, SKIP TO QUESTION 4***
☐ peritoneal dialysis (PD) ***IF YES, SKIP TO QUESTION 6***

4. CHRONIC HAEMODIALYSIS DURING THIS PREGNANCY

Please skip this section and move to Section 4 if you have attached deidentified dialysis charts.

	PRE-PREGNANCY	1ST TRIMESTER (1-13 WEEKS)	2ND TRIMESTER (14-27 WEEKS)	3RD TRIMESTER (28+ WEEKS)
Pre dialysis weight	kg	kg	kg	kg
Post dialysis weight	kg	kg	kg	kg
No. of dialysis sessions per week				
No. of hours per dialysis session				
Highest pre-dialysis urea (mmol/L)				
Heparin during dialysis	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐
Dialysate K+ (mmol/L)				
Dialysate Bicarbonate (mmol/L)				
Dialysate Calcium (mmol/L)				
Erythropoietin administration	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐
Iron administration	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐
Site of dialysis *(choose one)*	Hospital ☐ Home ☐ Satellite Unit ☐	Hospital ☐ Home ☐ Satellite Unit ☐	Hospital ☐ Home ☐ Satellite Unit ☐	Hospital ☐ Home ☐ Satellite Unit ☐
Nocturnal haemodialysis	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐

SECTION 3

5. **Did this woman have any vascular access for dialysis during this pregnancy?**
Yes ☐ No ☐ Not known ☐

IF NO SKIP TO SECTION 4

(If yes) please answer questions below

5.1. **Did this woman have a pre-existing functioning arteriovenous fistula in situ?**
Yes ☐ No ☐ Not known ☐
(If yes) type of fistula (choose one) ☐ Native fistula
☐ Artificial graft

5.2. **Was an arteriovenous fistula created during THIS pregnancy?**
Yes ☐ No ☐ Not known ☐
If yes
Date at of creation ____/___/_____
Serum creatinine at creation _____ (µmol/L)

5.3. **Was any other vascular access for dialysis used during this pregnancy?**
Yes ☐ No ☐ Not known ☐
(*If yes)* Temporary Catheter (Vascath) Yes ☐ No ☐ Not known ☐
(If yes) Date of insertion ____/___/_____

Tunnelled Catheter (Permcath) Yes ☐ No ☐ Not known ☐
(If yes) Date of insertion ____/___/_____

Access Related Complications

5.4. Sepsis / bacteraemia Yes ☐ No ☐ Not known ☐
(If yes) Date ____/___/_____
Organism _____
Antibiotics _____
Other details _____

5.5. Thrombosis Yes ☐ No ☐ Not known ☐
(If yes) Date ____/___/_____

Other details _____

5.6. Bleeding Yes ☐ No ☐ Not known ☐
5.7. Difficulty needling Yes ☐ No ☐ Not known ☐
5.8. Vessel stenosis requiring angioplasty Yes ☐ No ☐ Not known ☐
5.9. Other Yes ☐ No ☐ Not known ☐
(If yes) specify _____

6. PERITONEAL DIALYSIS (PD)

6.1. **Was this woman receiving any peritoneal dialysis (PD) during DURING this pregnancy?**
Yes ☐ No ☐ Not known ☐ ***IF NO, SKIP TO SECTION 4***

(If yes) choose one ☐ Automated
☐ Ambulatory (manual)

6.2. **PD Regime in each trimester** *(% glucose, additional icodextran and number of exchanges – please contact the AMOSS team for assistance with data collection – amoss@uts.edu.au or (02) 9514 8041)*

1st Trimester Regime

_____
_____
_____
_____
_____

SECTION 3

2nd Trimester Regime

_____
_____
_____
_____
_____

3rd Trimester Regime

_____
_____
_____
_____
_____

6.3. Did PD peritonitis occur during this pregnancy?
Yes ☐ No ☐ Not known ☐
(*If yes)* Date ____/___/_____
Organism _____
Antibiotics _____
Other (details) _____

6.4. Did a PD catheter exit site infection occur during this pregnancy?
Yes ☐ No ☐ Not known ☐
(If yes) Date ____/___/_____
Organism _____
Antibiotics _____
Other (details) _____

6.5. Was PD adequacy measured during this pregnancy?
Yes ☐ No ☐ Not known ☐
(If yes) Date ____/___/_____
Adequacy result _____ *(free text)*

6.6. Was residual urine output measured during this pregnancy?
Yes ☐ No ☐ Not known ☐
(*If yes)* Date ____/___/_____
Volume _____ (ml)

6.7. Was a Peritoneal Equilibrium Test (PET) performed during this pregnancy?
Yes ☐ No ☐ Not known ☐
(If yes) Date ____/___/_____
Result _____

6.8. Did any other complications of Peritoneal Dialysis occur during this pregnancy?
Yes ☐ No ☐ Not known ☐
(If yes) Details _____
_____

SECTION 4: MEDICATIONS AND OTHER THERAPIES

1. Anti-Hypertensive Medications PRIOR to Pregnancy

1.1. Did this woman take ACE Inhibitors *(e.g. perindopril, ramipril, enalapril, captopril)* or Angiotensin Receptor Blockers *(e.g. irbesartan, candesartan, telmisartan)* PRIOR to this pregnancy?

***(if yes)* Did use of ACE Inhibitors or Angiotensin Receptor Blockers cease PRIOR to this conception?**
Yes ☐ No ☐ Not known ☐

2. ANTI-HYPERTENSIVE MEDICATIONS

	PRE-PREGNANCY	ANTEPARTUM	INTRAPARTUM	POSTPARTUM	AT DISCHARGE
Methyldopa *(Aldomet, Hydopa)*	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐
Nifedipine *(Adalat, Adefin)*	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐
Labetalol *(Presolol, Trandate)*	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐
Oxprenolol (*Corbeton)*	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐
Other:	Yes ☐ No ☐ Not known ☐ **specify:**	Yes ☐ No ☐ Not known ☐ **specify:**	Yes ☐ No ☐ Not known ☐ **specify:**	Yes ☐ No ☐ Not known ☐ **specify:**	Yes ☐ No ☐ Not known ☐ **specify:**

3. IMMUNOSUPPRESSANT MEDICATIONS

	PRE-PREGNANCY	ANTEPARTUM	INTRAPARTUM	POSTPARTUM	AT DISCHARGE
Mycophenolate	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐
Azathioprine	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐
Sirolimus / everolimus	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐
Tacrolimus/ cyclosporine	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐
Prednisolone	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐	Yes ☐ No ☐ Not known ☐
Other:	Yes ☐ No ☐ Not known ☐ **specify:**	Yes ☐ No ☐ Not known ☐ **specify:**	Yes ☐ No ☐ Not known ☐ **specify:**	Yes ☐ No ☐ Not known ☐ **specify:**	Yes ☐ No ☐ Not known ☐ **specify:**
Other:	Yes ☐ No ☐ Not known ☐ **specify:**	Yes ☐ No ☐ Not known ☐ **specify:**	Yes ☐ No ☐ Not known ☐ **specify:**	Yes ☐ No ☐ Not known ☐ **specify:**	Yes ☐ No ☐ Not known ☐ **specify:**

4. **Were any other drugs (apart from anti-hypertensive agents and immunosuppressant agents) CEASED for this pregnancy?**

Yes ☐ No ☐ Not known ☐ *Choose one*

(If yes)

Name of drug _____ ☐ Ceased PRIOR to conception OR ☐ Ceased AFTER conception

Name of drug _____ ☐ Ceased PRIOR to conception OR ☐ Ceased AFTER conception

5. OTHER TREATMENTS DURING THIS PREGNANCY

5.1. **Aspirin** Yes ☐ No ☐ Not known ☐

5.2. **Erythropoietin** Yes ☐ No ☐ Not known ☐

(If yes) Name of agent _____

Treatment pre-pregnancy? Yes ☐ No ☐ Not known ☐

5.3. **Iron therapy** Yes ☐ No ☐ Not known ☐

(If yes) Oral Yes ☐ No ☐ Not known ☐

Intravenous Yes ☐ No ☐ Not known ☐

5.4. **Blood transfusion** Yes ☐ No ☐ Not known ☐

(If yes) Date___/___/_____

Number of units _____

Reason for transfusion

Chronic anaemia Yes ☐ No ☐ Not known ☐

Acute blood loss Yes ☐ No ☐ Not known ☐

Other Yes ☐ No ☐ Not known ☐

(If yes) specify _____

5.5. **Heparin (unfractionated or LMW)** Yes ☐ No ☐ Not known ☐

(If yes) Name of agent _____

Indication _____

Date started ___/___/_____

5.6. **Corticosteroids** (if not previously receiving corticosteroids)

Yes ☐ No ☐ Not known ☐ Not applicable ☐

(If yes) Methylprednisolone Yes ☐ No ☐ Not known ☐

(If yes) Indication _____

Date started ___/___/_____

Oral prednisolone Yes ☐ No ☐ Not known ☐

(If yes) Indication _____

Date started ___/___/_____

Betamethasone/dexamethasone for fetal lung maturity/thrombocytopenia Yes ☐ No ☐ Not known ☐

(If yes) Indication _____

Date started ___/___/_____

5.7. **Intravenous immunoglobulin** Yes ☐ No ☐ Not known ☐

(If yes) Indication _____

5.8. **Magnesium sulphate (MgSO4)** Yes ☐ No ☐ Not known ☐

SECTION 4

5.9. Antibiotics for TREATMENT of infection (NOT single doses)
Yes ☐ No ☐ Not known ☐
(If yes)
Name of agent _____
Indication _____

5.10. Antibiotics for PROPHYLAXIS against infection (NOT single doses)
Yes ☐ No ☐ Not known ☐
If yes
Name of agent _____
Indication _____

5.11. Non-steroidal anti-inflammatory drugs
Yes ☐ No ☐ Not known ☐
If yes
Name of agent _____
Indication _____

5.12. Folic acid
Yes ☐ No ☐ Not known ☐
If yes
Dose (mg/day) _____

5.13. Did the patient start any other new medications started during this pregnancy (excluding the above, multivitamins, Vitamin D and calcium)?
Yes ☐ No ☐ Not known ☐
If yes
Name of agent/date commenced _____
_____

SECTION 5: ANTENATAL, BIRTH AND POSTPARTUM CARE

1. **Did this woman have pre-existing, known hypertension PRIOR to pregnancy?**
Yes ☐ No ☐ Not known ☐
(If yes)

1.1. Hypertension type (*choose one*)
- ☐ Untreated hypertension: Hypertensive > 140/90 mmHg, not on treatment **OR**
- ☐ Uncontrolled hypertension: Hypertensive > 140/90 mmHg, on anti-hypertensive therapy **OR**
- ☐ Controlled hypertension: Normotensive <= 140/90 mmHg, on anti-hypertensive therapy **OR**
- ☐ Not known

(If no or not known)

1.2. Did this woman develop newly diagnosed hypertension during this pregnancy?
Yes ☐ No ☐ Not known ☐
(If yes) Was hypertension first identified at the booking visit? Yes ☐ No ☐ Not known ☐
Date hypertension first detected: ____/____/_____

2. BLOOD PRESSURE READINGS IN THIS PREGNANCY (HIGHEST)

	PRE-PREGNANCY		AT BOOKING		1ST TRIMESTER (1-13 weeks)		2ND TRIMESTER (14-27 weeks)	
	Value	*Date*	*Value*	*Date*	*Value*	*Date*	*Value*	*Date*
Systolic (mmHg)								
Diastolic (mmHg)								

	3RD TRIMESTER (28+ weeks)		DELIVERY		DISCHARGE	
	Value	*Date*	*Value*	*Date*	*Value*	*Date*
Systolic (mmHg)						
Diastolic (mmHg)						

3. ANTENATAL SCREENING AND GROWTH SCANS
Please skip this question and move to question 4 if you have attached deidentified scan data

3.1. **Did this woman have 1st/2nd trimester antenatal screening during this pregnancy?**
Yes ☐ No ☐ Not known ☐
(*If yes)*

	Date	*Gestational age (weeks)*	*Value*
PAPPA MoM			
Nuchal translucency (NT) scan NT mm			
β-hCG MoM			
Adjusted Down Syndrome Risk			
Non-invasive prenatal test (NIPT)			
Umbilical artery pulsatility index (UAPI)			
Serum placental growth factor (PlGF)			
Other abnormalities			

SECTION 5

4. **Did this woman have a fetal anomaly or growth scan during this pregnancy?**
Yes ☐ No ☐ Not known ☐
(If yes) How many scans in total? _____ (number)

Please skip this section and move to question 5 if you have attached deidentified scan data

	1st SCAN		2nd SCAN		3rd SCAN*	
	Value	***%ile***	***Value***	***%ile***	***Value***	***%ile***
Date of scan						
Gestational age (weeks)						
Amniotic fluid index (AFI)	cm		cm		cm	
Crown-rump length (CRL)	mm		mm		mm	
Deepest vertical pocket (DVP)	cm		cm		cm	
Estimated fetal weight (EFW)	grams		grams		grams	
Biparietal diameter (BPD)	mm		mm		mm	
Head circumference (HC)	mm		mm		mm	
Abdominal circumference (AC)	mm		mm		mm	
Femur Length (FL)	mm		mm		mm	
Umbilical artery pulsatility index (UAPI)						
Uterine artery resistance index (UARI)	☐ Normal ☐ Abnormal ☐ Unilateral ☐ Bilateral ☐ Not known		☐ Normal ☐ Abnormal ☐ Unilateral ☐ Bilateral ☐ Not known		☐ Normal ☐ Abnormal ☐ Unilateral ☐ Bilateral ☐ Not known	
Uterine artery notching	☐ Mild ☐ Severe ☐ Unilateral ☐ Bilateral ☐ Not known		☐ Mild ☐ Severe ☐ Unilateral ☐ Bilateral ☐ Not known		☐ Mild ☐ Severe ☐ Unilateral ☐ Bilateral ☐ Not known	

**If more than three scans please attach deidentified results at the end of the survey.*

5. **Was pre-eclampsia diagnosed in this pregnancy?**
Yes ☐ No ☐ Not known ☐
(If yes) Date of onset of pre-eclampsia ____/____/_____

Pre-eclampsia features (present at any time)

5.1.	Hypertension (≥140/90 mmHg)	Yes ☐ No ☐ Not known ☐
5.2.	Proteinuria (urine P:Cr > 30 mg/mmol)	Yes ☐ No ☐ Not known ☐
5.3.	Low platelets (< 100,000 x 109/L)	Yes ☐ No ☐ Not known ☐
5.4.	High uric acid *(greater than the upper limit for local lab reference range for gestational age)*	Yes ☐ No ☐ Not known ☐
5.5.	Renal impairment	Yes ☐ No ☐ Not known ☐
5.6.	Liver function derangement	Yes ☐ No ☐ Not known ☐
5.7.	Headache	Yes ☐ No ☐ Not known ☐
5.8.	Upper abdominal or Right Upper quadrant pain	Yes ☐ No ☐ Not known ☐
5.9.	Vomiting	Yes ☐ No ☐ Not known ☐
5.10.	Neurological symptom (without seizures)	Yes ☐ No ☐ Not known ☐
5.11.	Seizures (Eclampsia)	Yes ☐ No ☐ Not known ☐
5.12.	Fetal growth restriction (<10th centile)	Yes ☐ No ☐ Not known ☐
5.13.	Oligohydramnios	Yes ☐ No ☐ Not known ☐
5.14.	Abnormal umbilical artery Dopplers	Yes ☐ No ☐ Not known ☐

SECTION 5

6. **Did this woman develop new-onset proteinuria in this pregnancy (if not detected prior to pregnancy or at booking)**?
Yes ☐ No ☐ Not known ☐
(*If yes)* Date proteinuria was first detected: ____/____/_____

7. **Did this woman have a urinary tract infection during this pregnancy?**
Yes ☐ No ☐ Not known ☐
(If yes) Date ___/___/_____ or gestational age
Organism _____
Treatment _____

8. **Did this woman have asymptomatic bacteriuria during this pregnancy?**
Yes ☐ No ☐ Not known ☐
(*If yes)* Date ___/___/_____
Treatment _____

9. **Was this woman admitted early (pre-37 weeks) for delivery?**
Yes ☐ No ☐
(*If yes)* Gestation admitted _____ weeks OR Date admitted ___/___/_____

10. **Monitoring During Delivery (beyond basic vital sign monitoring)**

10.1.	BP monitoring	Yes ☐ No ☐ Not known ☐
10.2.	Urine output	Yes ☐ No ☐ Not known ☐
10.3.	Arterial line	Yes ☐ No ☐ Not known ☐
10.4.	CVP line	Yes ☐ No ☐ Not known ☐
10.5.	Cardiac monitoring	Yes ☐ No ☐ Not known ☐
10.6.	CTG	Yes ☐ No ☐ Not known ☐
10.7.	Other	Yes ☐ No ☐ Not known ☐

(If yes) specify _____

11. **Did this woman receive an indwelling bladder catheter during labour/postpartum?**
Yes ☐ No ☐ Not known ☐

12. **Did any of the following events/interventions occur during labour or delivery?**

12.1. Oliguria (urine output <30ml/hour for > 2 hours) Yes ☐ No ☐ Not known ☐

12.2. Severe hypertension (either BP ≥160 systolic or ≥110 diastolic (mmHg)) Yes ☐ No ☐ Not known ☐

12.3. High potassium (≥6.0 mmol/L or requiring treatment) Yes ☐ No ☐ Not known ☐

12.4. Low blood pressure <90 mmHg Yes ☐ No ☐ Not known ☐
(If yes) Fluid resuscitation only Yes ☐ No ☐ Not known ☐
Inotropes Yes ☐ No ☐ Not known ☐

12.5. Blood/platelet transfusion Yes ☐ No ☐ Not known ☐
(If yes) Number of units _____ (RBC/platelets)

SECTION 5

13. **Did any of the following events/interventions occur post-partum prior to discharge?**

13.1. Oliguria (urine output <30ml/hour for > 2 hours) Yes ☐ No ☐ Not known ☐

13.2. Severe hypertension (either BP ≥160 systolic or ≥110 diastolic (mmHg)) Yes ☐ No ☐ Not known ☐

13.3. High potassium (≥6.0 mmol/L or requiring treatment) Yes ☐ No ☐ Not known ☐

13.4. Low blood pressure <90 mmHg Yes ☐ No ☐ Not known ☐
(If yes) Fluid resuscitation only Yes ☐ No ☐ Not known ☐
Inotropes Yes ☐ No ☐ Not known ☐

13.5. Blood/platelet transfusion Yes ☐ No ☐ Not known ☐
(If yes) Number of units _____ (RBC/platelets)

14. **Did this woman receive non-steroidal anti-inflammatory medication postpartum prior to discharge?**
Yes ☐ No ☐ Not known ☐
(*If yes)* Name of agent _____ Indication _____

15. **Was there a plan for follow up with the following medical providers?**
15.1. GP Yes ☐ No ☐ Not known ☐
15.2. High-risk clinic Yes ☐ No ☐ Not known ☐
15.3. Nephrologist Yes ☐ No ☐ Not known ☐
15.4. Other Yes ☐ No ☐ Not known ☐

16. **Is there any other relevant information regarding this patient? Please provide details.**

_____

_____

_____

_____

_____

_____

_____

_____

_____

End of Survey. Thank you!