ENTRY FORM

PLEASE COMPLETE BEFORE RANDOMISING THE WOMAN

ABOUT YOUR HOSPITAL *(please ensure all information below is contained in the medical records)*

1. Country	
2. Hospital code *(in your Study File)*	

ABOUT THE PATIENT

3. Patient's initials *(first name/last name)*		**4.** Patient Hospital identification number					
5. Do you know her date of birth? *(circle)*	a) YES	*day*	*month*	*year*	b) NO – approximate age		*years*

ABOUT THE DELIVERY

6. Delivery of the baby in this hospital? *(circle)*	YES	NO				
7. Type of delivery *(circle)*	VAGINAL	CAESAREAN SECTION				
8. Date of delivery	*day*	*month*	*year*			
9. Time of delivery *(24-hour clock)*	*hours*	*minutes*				
10. Placenta fully delivered? *(circle)*	YES	NO				
11. Primary cause of haemorrhage? *(circle)*	UTERINE ATONY	PLACENTA PRAEVIA/ACCRETA	SURGICAL TRAUMA/TEARS	OTHER	UNKNOWN	
12. Systolic Blood Pressure		*mmHg (most recent measurement prior to randomisation)*				
13. Estimated volume of blood loss		*Millilitres (estimated from delivery of baby to immediately prior to randomisation)*				
14. Any uterotonic prophylaxis given?	YES	NO	UNKNOWN			
15. Clinical signs of haemodynamic instability?	YES	NO	*Haemodynamic instability assessment based on clinical signs (e.g.low BP, tachycardia, falling urine output) that requires an intervention (e.g. intravenous fluids)*			

RANDOMISATION INFORMATION

16. Eligible? *(circle)*	**YES** *(Get the lowest available number treatment pack and follow instructions)*		**NO** *(Do not randomise, record on screening log)*	
17. Consent obtained from? *(circle)*	Woman	Relative	Other representative	Waiver
18. Insert treatment pack number here	**BOX**		**PACK**	
19. Date of randomisation	*day*	*month*	*year*	**20.** Time of randomisation *(24-hour clock)* *hours* *minutes*
21. a)Name of person randomising patient		b) Signature		

PLEASE SEND THIS FORM TO THE COORDINATING CENTRE **IMMEDIATELY** AFTER RANDOMISATION

SEE GUIDANCE OVERLEAF

DATA FORMS GUIDANCE

AFTER COMPLETING THIS PAPER FORM, YOU CAN:

- Enter these data directly into the trial database (username and password required)

  www.thewomantrial.Lshtm.ac.uk

- Complete an Electronic Data Form (EDF) and send by email or upload to the trial intranet at *www.thewomantrial.Lshtm.ac.uk*
- Send as a secure scanned document by email to *woman.data@Lshtm.ac.uk*
- Fax to +44 20 7299 4663
- Store original form in the Investigator's Study File
- **PLEASE GIVE A COPY OF THIS COMPLETED FORM TO THE PERSON RESPONSIBLE FOR COMPLETING THE OUTCOME FORM AT YOUR HOSPITAL**

NOTES:

FOR ADVERSE EVENTS, UNBLINDING AND OTHER URGENT ENQUIRIES PLEASE TELEPHONE +44(0)7768 707500

PLEASE NOTE: IF YOUR QUERY IS NOT URGENT PLEASE USE THE NORMAL CONTACT DETAILS IN THE INVESTIGATOR'S STUDY FILE.