The presentations and management of women with platelet function disorders and platelet number disorders in the Obstetrics and Gynaecology settings can be varied and there is limited clinical experience in this area due to the rarity and different types of platelet function disorders. We therefore use this international data registry to capture data worldwide to help culminate knowledge and experience in the different presentations, complications and management approaches. This would aid in the development of a guidance document and an original article.

Participants should ensure they keep a local confidential list correlating to their patient numbering used on this registry, as this registry is anonymized.

If you have any questions regarding this registry, please contact the Principal Investigator, Dr. Deborah Obeng-Tuudah at d.obeng-tuudah@nhs.net.

Click on the following attachment below to view the entire survey:

[Attachment: "OB_GYN Outcomes of Women With Platelet Function Disorders full survey.pdf"]
<table>
<thead>
<tr>
<th>Country</th>
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<tbody>
<tr>
<td>Philippines</td>
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<td>Zambia</td>
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<td>Zimbabwe</td>
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(Please use the drop down tab to select)

Centre Name: ________________________________
Patient Data

Outcomes of Women with Platelet Function Disorders

Please contribute to this study by inputting your patients’ data into the anonymized data registry.

**Patient Demographics**

Patient number
Please start your patient numbering with 001, 002, etc

Age (In Years):

(Enter whole numbers only.)

Ethnic origin
(if mixed, tick more than one box) - is to describe where the patient’s family originates from, as distinct from where they were born.

- British European (eg England, Wales)
- Irish European (eg Northern Ireland, Ireland)
- West European (eg France, Germany)
- East European (eg Poland, Romania)
- North European (eg Sweden, Denmark)
- South European (eg Greece, Spain)
- North African (eg Egypt, Sudan)
- East African (eg Ethiopia, Kenya)
- Central African (eg Cameroon, Congo)
- South African (eg Botswana, South Africa)
- West African (Gambia, Ghana)
- Middle Eastern (eg Iraq, Turkey, Israel)
- South Asia (eg India, Pakistan, Bangladesh, Sri Lanka)
- Southeast Asia (eg Thailand, Philippines, Malaysia)
- East Asia (eg China, Japan, Korea)
- Caribbean (eg Barbados, Jamaica)
- North America (eg Canada, United States)
- Central America (eg Costa Rica, El Salvador)
- South America (eg Argentina, Brazil)
- Other (please specify below)

Please specify your ethnicity

Diagnosis of Inherited Platelet Function Disorder (IPFDs) or Inherited Platelet Number Disorder (IPNDs)

Age at diagnosis (years):

If age at diagnosis is in months, enter fractional age in years ie. divide by 12

Main Presenting Symptom(s) at Diagnosis:
Other Bleeding Symptoms:  
- Epistaxis  
- Cutaneous bruises  
- Prolonged bleeding from minor wounds  
- Bleeding from oral cavity  
- Excessive bleeding at tooth extraction  
- Excessive bleeding after other surgery  
- Muscle haematomas  
- Haemarthrosis  
- CNS bleeding  
- GI bleeding  
- Heavy menstrual bleeding / Menorrhagia  
- Postpartum Haemorrhage (PPH)  
- Other(s) (specify below)

Other Bleeding Symptom(s) (if not listed above):  
__________________________________________

ISTH Bat Bleeding Score:  
Please click here to calculate your score.

ISTH BAT Bleeding Score (July 2011 revision):  
__________________________________

Answer the following questions based on results of investigations. Please include as much information as possible and state if normal (N) or abnormal (B):

Haemoglobin (Hb)  
Hb value and measurement units:  
__________________________________

Hb laboratory normal reference range:  
__________________________________

Platelet count  
Platelet count value and measurement units:  
__________________________________

Platelet count laboratory normal reference range:  
__________________________________

Mean Platelet Volume (MPV)  
Mean platelet volume (MPV) value and measurement units:  
__________________________________

Mean platelet volume (MPV) laboratory normal reference range:  
__________________________________

Platelet Diameter
Platelet diameter value and measurement units: ____________________________

Platelet diameter laboratory normal reference range: ____________________________

PT

PT value and measurement units: ____________________________

PT laboratory normal reference range: ____________________________

INR

INR value and measurement units: ____________________________

INR laboratory normal reference range: ____________________________

APTT

APTT value and measurement units: ____________________________

APTT laboratory normal reference range: ____________________________

FVIII:C

FVIII:C value and measurement units: ____________________________

FVIII:C laboratory normal reference range: ____________________________

FXI:C

FXI:C value and measurement units: ____________________________

FXI:C laboratory normal reference range: ____________________________

IX:C

IX:C value and measurement units: ____________________________

IX:C laboratory normal reference range: ____________________________
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<th>Value and Measurement Units</th>
<th>Laboratory Normal Reference Range</th>
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<tr>
<td>VWF:RCo</td>
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<tr>
<td>VWF:CBA</td>
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<td>Clauss Fibrinogen</td>
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<td>Other Coagulation Factor Assay</td>
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<td>Bleeding Time</td>
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<td>Question</td>
<td>Response</td>
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<td>Secretion Assay or Nucleotide Quantitation (please specify):</td>
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<td>Secretion Assay or Nucleotide Quantitation laboratory normal reference range:</td>
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<td>Diagnostic Platelet Function Test:</td>
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<tr>
<td>Type of Platelet Aggregation:</td>
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<tr>
<td>(e.g. light transmission aggregometry, multiplate.)</td>
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<td></td>
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<tr>
<td>Is it whole blood or plasma based aggregation?</td>
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<tr>
<td>☐ Whole blood</td>
<td></td>
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<tr>
<td>☐ Plasma based aggregation</td>
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<td>Please State the Abnormal Agonist:</td>
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<tr>
<td>Platelet glycoprotein assays information if done:</td>
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<tr>
<td>Any additional tests or information: e.g. thromboelastography, IMPACT-R:</td>
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<td></td>
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<tr>
<td>(e.g. thromboelastography)</td>
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<td>Type of Inherited Platelet Function Disorders (IPFDs):</td>
<td></td>
<td></td>
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<tr>
<td>-----------------------------------------------------</td>
<td></td>
<td></td>
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<tr>
<td>☐ ARC syndrome</td>
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<tr>
<td>☐ Bernard-Soulier syndrome</td>
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<td></td>
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<tr>
<td>☐ Chediak-Higashi Syndrome</td>
<td></td>
<td></td>
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<tr>
<td>☐ Combined alpha-delta granule deficiency</td>
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<tr>
<td>☐ Cytosolic phospholipase A2 (cPLA2) deficiency</td>
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<tr>
<td>☐ COX-1 deficiency</td>
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<tr>
<td>☐ Defect of thromboxane A2 receptor</td>
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<tr>
<td>☐ Defects in collagen receptor</td>
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<td></td>
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<tr>
<td>☐ Delta granule deficiency</td>
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<tr>
<td>☐ Familial platelet disorder and predisposition to</td>
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<tr>
<td>acute myelogenous leukemia (RUNX-1 defect)</td>
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<tr>
<td>☐ FLI1-related delta granule defect</td>
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<tr>
<td>☐ Glanzmann thrombasthenia</td>
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<tr>
<td>☐ Gray platelet syndrome (or Alpha granule</td>
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<tr>
<td>deficiency) with mutation in GFI1B or NBEAL2</td>
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<tr>
<td>☐ Hermansky-Pudlak syndrome</td>
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<tr>
<td>☐ P2Y12 deficiency</td>
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<tr>
<td>☐ PKC deficiency</td>
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<tr>
<td>☐ Platelet-type Von Willebrand Disease</td>
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<tr>
<td>☐ Primary secretion defect</td>
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<td>☐ Quebec platelet disorder</td>
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<td>☐ Scott syndrome</td>
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<td>☐ Stormorken syndrome</td>
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<td>☐ Thromboxane synthase deficiency</td>
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<tr>
<td>☐ Platelet function disorder - type unclassified</td>
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<tr>
<td>☐ Platelet disorder plus coagulation factor defect</td>
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<td>(specify below):</td>
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<tr>
<td>☐ Other platelet function disorder (specify below):</td>
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<td>(Please check all that apply.)</td>
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<table>
<thead>
<tr>
<th>Platelet Disorder Plus Coagulation Factor Defect</th>
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<tr>
<td>(please specify):</td>
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</tbody>
</table>

| Other Platelet Function Disorder (if not listed |
| above):                                         |
|                                                  |

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06/25/2019 11:25

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Confidential
### Type of Inherited Platelet Number Disorder (IPNDs):
- ACTN1-related thrombocytopenia
- ANKRD26-related thrombocytopenia
- Bernard Soulier Syndrome
- Congenital amegakaryocytic thrombocytopenia (CAMT)
- CYCS-related thrombocytopenia
- DIAPH1-related thrombocytopenia
- ETV6-related thrombocytopenia
- FLNA-related thrombocytopenia
- FYB-related thrombocytopenia
- GATA1-related diseases
- GFI1B-related thrombocytopenia
- ITGA2B/ITGB3 related thrombocytopenia
- MYH9-related disease
- Paris-Trousseau thrombocytopenia - Jacobsen syndrome
- PRKACG-related thrombocytopenia
- Radioulnar synostosis with amegakaryocytic thrombocytopenia
- SLFN14-related thrombocytopenia
- SRC-related thrombocytopenia
- THPO-related disease
- Thrombocytopenia associated with sitosterolemia (STSL)
- Thrombocytopenia-absent radius syndrome (TAR)
- TPM4-related thrombocytopenia
- TRPM7-related thrombocytopenia
- TUBB1-related thrombocytopenia
- Wiskott-Aldrich syndrome
- X-linked thrombocytopenia
- Other inherited platelet number disorder (specify below)

(Please check all that apply.)

### Other inherited platelet number disorder (please specify):

### Have patient had genetic analysis?
- Yes
- No

### Is the pathogenic genetic variant causing platelet function disorder known?
- Yes
- No
- Awaited

### State pathogenic genetic variant using HGVS nomenclature:

### Family history of IPFDs or IPNDs?
- Yes
- No

### Presence of consanguinity?
- Yes
- No
### Other medical conditions

Please state if other medical conditions present eg. Asthma, Hypertension, Diabetes:

__________________________

### Gynecological History

#### Age at Menarche:

(whole number only)

#### Menstrual Cycle:

#### Length of menstrual bleeding in days:

__________________________

#### Frequency of menstrual bleeding in days (from first day of menstrual bleeding/period to last day before the next episode of bleeding):

__________________________

#### Menstrual cycle regular or irregular?

- [ ] Regular
- [x] Irregular

#### History of heavy menstrual bleeding (HMB)?

- [ ] Yes
- [x] No

#### HMB reported from Menarche?

- [ ] Yes
- [x] No

#### Age when HMB was reported:

(whole number only)

#### Had consultation for HMB:

- [ ] No consultation
- [ ] GP / Family doctor only
- [x] Gynaecologist

#### PBAC score (if known):

__________________________

#### Investigations undertaken for HMB and findings:

- [ ] Initial blood count and/or clotting tests
- [ ] Pelvic ultrasound
- [ ] Hysteroscopy
- [ ] CT / MRI pelvis
- [ ] Other (specify)

#### Initial blood count and/or clotting tests findings:

__________________________

#### Pelvic ultrasound findings:

__________________________

#### Hysteroscopy findings:

__________________________

#### CT / MRI pelvis findings:

__________________________
Please specify other investigations undertaken for HMB and findings:

Other gynecological pathology found?

- Endometriosis
- Fibroids
- Adenomyosis
- Ovarian cysts (types):
  - Other (specify)

Specify type of Ovarian Cysts:

Specify other gynecological pathology found:

Any history of acute HMB/menorrhagia needing attendance to emergency department and/or hospital admission?

- Yes
- No

If yes, please provide additional information:

Acute Treatment of HMB:

- Packed red cells
- Other Blood Products (state type and units)
- Progestagens Hormonal Therapy
- Oestrogen Hormonal Therapy
- Combined Oral Contraceptive Pill
- Antifibrinolytics Agent (e.g. Tranexamic Acid)
- Iron Therapy (Oral or Intravenous)
- Desmopressin
- Surgery (please specify)
- Other treatment (please specify)

(Enter type, dose/units given and/or frequency below.)

Total Units of Packed Red Cells given:

Other Blood Products Type:

Other Blood Products Dose/Units:

Other Blood Products Frequency:

Progestagens Hormonal Therapy Type:

Progestagens Hormonal Therapy Dose:

Progestagens Hormonal Therapy Frequency:
Oestrogen Hormonal Therapy Type: ____________________________________

Oestrogen Hormonal Therapy Dose: ____________________________________

Oestrogen Hormonal Therapy Frequency: ________________________________

Combined Oral Contraceptive Pill Type: ________________________________

Combined Oral Contraceptive Pill Dose: ________________________________

Combined Oral Contraceptive Pill Frequency: __________________________

Antifibrinolytics (e.g. Tranexamic Acid) Type: __________________________

Antifibrinolytics (e.g. Tranexamic Acid) Dose: __________________________

Antifibrinolytics (e.g. Tranexamic Acid) Frequency: ____________________

Iron Therapy (Oral or Intravenous) Type: ______________________________

Iron Therapy (Oral or Intravenous) Dose: ______________________________

Iron Therapy (Oral or Intravenous) Frequency: _________________________

Desmopressin Type: ________________________________________________

Desmopressin Dose: ________________________________________________

Desmopressin Frequency: __________________________________________

Provide additional information about surgical treatment(s) for HMB.

Please specify other treatment:

Regular or maintenance treatment given to reduce HMB?  
☐ Yes  ☐ No
| Initial treatment: | ☐ Antifibrinolytics (e.g. Tranexamic Acid)  
☐ Combined Oral Contraceptive Pill  
☐ Cyclical Progestagens (e.g. Norethisterone, Provera)  
☐ Mirena IUS  
☐ Hysteroscopy and Endometrial polypectomy/curettings  
☐ Endometrial Ablation  
☐ Hysterectomy  
☐ Iron Therapy (Oral or Intravenous)  
☐ Desmopressin (DDAVP)  
☐ Other treatment (specify below)  
(Check all options which apply. Enter type, does/units given and/or frequency below.) |
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Antifibrinolytics (e.g. Tranexamic Acid) Type:</td>
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<tr>
<td>Antifibrinolytics (e.g. Tranexamic Acid) Dose:</td>
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<td>Antifibrinolytics (e.g. Tranexamic Acid) Frequency:</td>
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<td>Combined Oral Contraceptive Pill Type:</td>
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<td>Cyclical Progestagens (e.g. Norethisterone, Provera) Type:</td>
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<td>Cyclical Progestagens (e.g. Norethisterone, Provera) Dose:</td>
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<tr>
<td>Cyclical Progestagens (e.g. Norethisterone, Provera) Frequency:</td>
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<tr>
<td>Iron Therapy Type:</td>
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<td>Iron Therapy Dose:</td>
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<tr>
<td>Desmopression (DDAVP) Type:</td>
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<td>Answer</td>
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<td>Desmopressin Frequency:</td>
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<td>Please specify other treatment:</td>
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<tr>
<td>Duration of treatment in months:</td>
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<tr>
<td>Response to treatment:</td>
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<td>Second line treatment:</td>
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<td>Antifibrinolytics (e.g. Tranexamic Acid):</td>
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<td>Combined Oral Contraceptive Pill:</td>
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<td>Cyclical Progestagens (e.g. Norethisterone, Provera)</td>
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<tr>
<td>Mirena IUS</td>
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<td>Hysteroscopy and Endometrial polyectomy/currettings</td>
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<td>Endometrial Ablation</td>
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<td>Hysterectomy</td>
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<tr>
<td>Iron Therapy (Oral or Intravenous)</td>
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<tr>
<td>Desmopressin (DDAVP)</td>
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<tr>
<td>Other treatment (specify below)</td>
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<td>Antifibrinolytics (e.g. Tranexamic Acid) Type:</td>
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<td>Antifibrinolytics (e.g. Tranexamic Acid) Dose:</td>
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<td>Combined Oral Contraceptive Pill Type:</td>
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<td>Cyclical Progestagens (e.g. Norethisterone, Provera) Dose:</td>
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<tr>
<td>Cyclical Progestagens (e.g. Norethisterone, Provera) Frequency:</td>
<td></td>
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<tr>
<td>Iron Therapy (Oral or Intravenous) Type:</td>
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</tbody>
</table>
Iron Therapy (Oral or Intravenous) Dose: ________________

Iron Therapy (Oral or Intravenous) Frequency: ________________

Desmopressin (DDAVP) Type: ________________

Desmopressin (DDAVP) Dose: ________________

Desmopressin (DDAVP) Frequency: ________________

Please specify other treatment: ________________

Duration of treatment in months: ________________

Response to treatment:  
- Not effective - additional/alternative treatment needed  
- Effective - no further management needed

Third line treatment: 
- Antifibrinolytics (e.g. Tranexamic Acid):  
- Combined Oral Contraceptive Pill  
- Cyclical Progestagens (e.g. Norethisterone, Provera)  
- Mirena IUS  
- Hysteroscopy and Endometrial polypectomy/currettings  
- Endometrial Ablation  
- Hysterectomy  
- Iron Therapy (Oral or Intravenous):  
- Desmopressin (DDAVP)  
- Other treatment (specify below)  
(Check all options which apply. Enter type, does/units given and/or frequency below.)

Antifibrinolytics (e.g. Tranexamic Acid) Type: ________________

Antifibrinolytics (e.g. Tranexamic Acid) Dose: ________________

Antifibrinolytics (e.g. Tranexamic Acid) Frequency: ________________

Combined Oral Contraceptive Pill Type: ________________

Combined Oral Contraceptive Pill Dose: ________________

Combined Oral Contraceptive Pill Frequency: ________________
<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Type</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cyclical Progestagens (e.g. Norethisterone, Provera)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iron Therapy (Oral or Intravenous)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desmopressin (DDAVP)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please specify other treatment:

Duration of treatment in months:

Response to treatment:  
- Not effective - additional/alternative treatment needed  
- Effective - no further management needed  
(If not effective, please give further information in the additional information box at the end of this questionnaire.)

Any blood products needed regularly during periods?  
- Yes  
- No

Provide additional information regarding blood products needed regularly during periods.

Any history of ovulation bleeding?  
- Yes  
- No
<table>
<thead>
<tr>
<th>What treatment was given for ovulation bleeding?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Antifibrinolytic agent (eg. Tranexamic acid)</td>
</tr>
<tr>
<td>☐ Combined oral contraceptive pill</td>
</tr>
<tr>
<td>☐ Cyclical progestagens (eg. Norethisterone, Provera)</td>
</tr>
<tr>
<td>☐ Blood transfusion (packed red cells)</td>
</tr>
<tr>
<td>☐ Desmopression (DDAVP)</td>
</tr>
<tr>
<td>☐ Platelet transfusion</td>
</tr>
<tr>
<td>☐ Other blood products (specify below)</td>
</tr>
<tr>
<td>☐ Oophorectomy</td>
</tr>
<tr>
<td>☐ Other surgical interventions (specify below)</td>
</tr>
<tr>
<td>☐ Other treatment (please give more information) (Please check all that apply.)</td>
</tr>
</tbody>
</table>

Specify other blood products: ______________________________

Please specify other surgical intervention: ___________________

Please give more information for other treatment: ___________

History of regular mid-cycle pain? ☐ Yes ☐ No

<table>
<thead>
<tr>
<th>What treatment was given for regular mid-cycle pain?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Antifibrinolytic agent (eg. Tranexamic acid)</td>
</tr>
<tr>
<td>☐ Combined oral contraceptive pill</td>
</tr>
<tr>
<td>☐ Cyclical progestagens (eg. Norethisterone, Provera)</td>
</tr>
<tr>
<td>☐ Blood transfusion (packed red cells)</td>
</tr>
<tr>
<td>☐ Desmopression (DDAVP)</td>
</tr>
<tr>
<td>☐ Platelet transfusion</td>
</tr>
<tr>
<td>☐ Other blood products (specify below)</td>
</tr>
<tr>
<td>☐ Oophorectomy</td>
</tr>
<tr>
<td>☐ Other surgical interventions (please specify)</td>
</tr>
<tr>
<td>☐ Other treatment (please give more information)    (Please check all that apply.)</td>
</tr>
</tbody>
</table>

Specify other blood products: ______________________________

Please specify other surgical interventions: _________________

Please give more information for other treatment: ___________

History of recurrent ovarian haemorrhagic cysts? ☐ Yes ☐ No
| What treatment was given for recurrent ovarian haemorrhagic cysts? |☐ Antifibrinolytic agent (eg. Tranexamic acid)  
☐ Combined oral contraceptive pill  
☐ Cyclical progestagens (eg. Norethisterone, Provera)  
☐ Blood transfusion (packed red cells)  
☐ Desmopression (DDAVP)  
☐ Platelet transfusion  
☐ Other blood products (specify below)  
☐ Oophorectomy  
☐ Other surgical interventions (please specify)  
☐ Other treatment (please give more information)  
(Please check all that apply.) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify other blood products:</td>
<td></td>
</tr>
<tr>
<td>Please specify other surgical interventions:</td>
<td></td>
</tr>
<tr>
<td>Please give more information for other treatment:</td>
<td></td>
</tr>
</tbody>
</table>
| History of acute abdomen with haemoperitoneum? |☐ Yes  
☐ No |
| What treatment was given acute abdomen with haemoperitoneum? |☐ Antifibrinolytic agent (eg. Tranexamic acid)  
☐ Combined oral contraceptive pill  
☐ Cyclical progestagens (eg. Norethisterone, Provera)  
☐ Blood transfusion (packed red cells)  
☐ Desmopression (DDAVP)  
☐ Platelet transfusion  
☐ Other blood products (specify below)  
☐ Oophorectomy  
☐ Other surgical interventions (please specify)  
☐ Other treatment (please give more information)  
(Please check all that apply.) |
| Specify other blood products: | |
| Please specify other surgical interventions: | |
| Please give more information for other treatment: | |
| History of anaemia? |☐ Yes  
☐ No |
| If Yes, treatment(s) given for anaemia: |☐ Oral Iron  
☐ Intravenous Iron  
☐ Transfusion of Packed Red Cells  
☐ Other (specify):  
(Please check all that apply.) |
<p>| Other Treatment (if not listed above): | |</p>
<table>
<thead>
<tr>
<th><strong>Obstetric History</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Has the patient ever been pregnant (Including miscarriages, terminated pregnancies, and/or deliveries)?</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td><strong>Background History</strong></td>
</tr>
<tr>
<td><strong>Gravidity (total number of pregnancies):</strong></td>
</tr>
<tr>
<td>(Enter whole numbers only (no text).)</td>
</tr>
<tr>
<td><strong>Parity (deliveries &gt;= 24 weeks):</strong></td>
</tr>
<tr>
<td>(Enter whole numbers only (no text).)</td>
</tr>
<tr>
<td><strong>Number of Miscarriages:</strong></td>
</tr>
<tr>
<td>(Enter whole numbers only (no text).)</td>
</tr>
<tr>
<td><strong>Number of Termination of Pregnancy (TOP):</strong></td>
</tr>
<tr>
<td>(Enter whole numbers only (no text).)</td>
</tr>
<tr>
<td><strong>History of miscarriage or TOP?</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td><strong>Miscarriage/TOP One:</strong></td>
</tr>
<tr>
<td><strong>Diagnosis of IPFDs or IPNDs:</strong></td>
</tr>
<tr>
<td>known</td>
</tr>
<tr>
<td><strong>Prophylactic haemostatic cover given to reduce risk of bleeding during miscarriage or TOP?</strong></td>
</tr>
<tr>
<td>Antifibrinolytic agent (eg. Tranexamic Acid)</td>
</tr>
<tr>
<td>Platelet Transfusion</td>
</tr>
<tr>
<td>No haemostatic cover (state reason) (Please check all that apply.)</td>
</tr>
<tr>
<td><strong>Please specify other products:</strong></td>
</tr>
<tr>
<td>____________________________</td>
</tr>
<tr>
<td><strong>Please state reason for no haemostatic cover for known diagnosis:</strong></td>
</tr>
<tr>
<td>____________________________</td>
</tr>
<tr>
<td><strong>Heavy bleeding during miscarriage or TOP?</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td><strong>How much bleeding occurred during miscarriage or TOP (EBL/quantify)?</strong></td>
</tr>
<tr>
<td>____________________________</td>
</tr>
<tr>
<td><strong>Treatment Given for Heavy Bleeding During Miscarriage or TOP:</strong></td>
</tr>
<tr>
<td>____________________________</td>
</tr>
<tr>
<td><strong>Any other history of miscarriage or TOP?</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>
## Miscarriage/TOP Two:

### Diagnosis of IPFDs or IPNDs:
- [ ] known
- [ ] unknown

### Prophylactic haemostatic cover given to reduce risk of bleeding during miscarriage or TOP?
- [x] Antifibrinolytic agent (eg. Tranexamic Acid)
- [ ] Desmopressin (DDAVP)
- [ ] Platelet Transfusion
- [ ] Other products (specify)
- [ ] No haemostatic cover (state reason)

(Please check all that apply.)

Please specify other products:
__________________________________

Please state reason for no haemostatic cover for known diagnosis:
__________________________________

Heavy bleeding during miscarriage or TOP?
- [x] Yes
- [ ] No

How much bleeding occurred during miscarriage or TOP (EBL/quantify)?
__________________________________

Treatment Given for Heavy Bleeding During Miscarriage or TOP:
__________________________________

Any other history of miscarriage or TOP?
- [x] Yes
- [ ] No

## Miscarriage/TOP Third

### Diagnosis of IPFDs or IPNDs:
- [ ] known
- [ ] unknown

### Prophylactic haemostatic cover given to reduce risk of bleeding during miscarriage or TOP?
- [x] Antifibrinolytic agent (eg. Tranexamic Acid)
- [ ] Desmopressin (DDAVP)
- [ ] Platelet Transfusion
- [ ] Other products (specify)
- [ ] No haemostatic cover (state reason)

(Please check all that apply.)

Please specify other products:
__________________________________

Please state reason for no haemostatic cover for known diagnosis:
__________________________________

Heavy bleeding during miscarriage or TOP?
- [x] Yes
- [ ] No

How much bleeding occurred during miscarriage or TOP (EBL/quantify)?
__________________________________

Treatment Given for Heavy Bleeding During Miscarriage or TOP:
__________________________________
Any other history of miscarriage or TOP?  
○ Yes  
○ No  

Miscarriage/TOP Four:

Diagnosis of IPFDs or IPNDs:  
○ known  
○ unknown  

Prophylactic haemostatic cover given to reduce risk of bleeding during miscarriage or TOP?  
☐ Antifibrinolytic agent (eg. Tranexamic Acid)  
☐ Desmopressin (DDAVP)  
☐ Platelet Transfusion  
☐ Other products (specify)  
☐ No haemostatic cover (state reason)  
(Please check all that apply.)  

Please specify other products:  
__________________________________  

Please state reason for no haemostatic cover for known diagnosis:  
__________________________________  

Heavy bleeding during miscarriage or TOP?  
○ Yes  
○ No  

How much bleeding occurred during miscarriage or TOP (EBL/quantify)?  
__________________________________  

Treatment Given for Heavy Bleeding During Miscarriage or TOP:  
__________________________________  

Please complete below questionnaire for all pregnancies reaching viability (>= 24 weeks gestation) until delivery.

Any viable (>=24 weeks gestation until delivery) pregnancies?  
○ Yes  
○ No  

Total Number of Viable Pregnancies:  
○ 0  
○ 1  
○ 2  
○ 3  
○ 4  
○ 5  

Pregnancy One

Year of Pregnancy:  
__________________________________  

Bleeding in early pregnancy?  
○ Yes  
○ No  

How much early bleeding occurred (EBL/Quantify)?  
__________________________________
| Haemostatic treatment given for early pregnancy bleeding: | □ Antifibrinolytic agent eg Tranexamic Acid  
□ Desmopressin (DDAVP)  
□ Platelet transfusion  
□ Other products (specify below)  
□ No haemostatic treatment - diagnosis of platelet function disorder known (state reason)  
□ No haemostatic treatment - diagnosis of platelet function disorder unknown (Please check all that apply.) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Please specify other products:</td>
<td></td>
</tr>
<tr>
<td>Please state the reason for no haemostatic treatment - diagnosis of platelet function disorder known:</td>
<td></td>
</tr>
</tbody>
</table>
| Antepartum haemorrhage (bleeding after 24 weeks)? | □ Yes  
□ No |
| How much antepartum haemorrhage (bleeding after 24 weeks) occurred (EBL/Quantify)? |  |
| Haemostatic treatment given for APH: | □ Antifibrinolytic agent eg Tranexamic Acid  
□ Desmopressin (DDAVP)  
□ Platelet transfusion  
□ Other products (specify below)  
□ No haemostatic treatment - diagnosis of platelet function disorder known (state reason)  
□ No haemostatic treatment - diagnosis of platelet function disorder unknown (Please check all that apply.) |
| Please specify other products: |  |
| Please state reason for no haemostatic treatment - diagnosis of platelet function disorder known: |  |
| Presence of Pre-Eclampsia (PET)? | □ Yes  
□ No |
| Pre-eclampsia is defined as high blood pressure >= 140/90 with significant proteinuria of >= 300mg in 24 hr urine (or significant alternate proteinuria quantification e.g. urine PCR >= 30 or urine dipstick >= 1+) after 20 weeks of pregnancy. |  |
| Please provide the following details regarding positive pre-eclampsia diagnosis: |  |
| Review the attached document below to classify the severity of Pre-eclampsia: | [Attachment: "Classification of PET severity.pdf"] |
| State severity of PET: | □ Mild  
□ Moderate  
□ Severe |
Platelet Count: ________________________________

HELLP Syndrome:  
- Yes  
- No

If Yes, please give more information on clinical course, investigations including haemoglobin, liver enzymes and management: ________________________________

Presence of small for gestational age or intrauterine growth restriction?  
- Yes  
- No

Was antiplatelet antibody tested in this pregnancy?  
- Yes  
- No

Was the result positive or negative?  
- Positive  
- Negative

Please specify the type and titre if known: ________________________________

Did the mother require referral to fetal medicine for monitoring?  
- Yes  
- No

Did she require IVIG treatment?  
- Yes  
- No

Did the baby require in-utero platelet transfusion?  
- Yes  
- No

Was the mother delivered preterm because of NAIT (Neonatal Alloimmune thrombocytopenia)?  
- Yes  
- No

**Delivery One**

Gestational Age at Delivery (weeks): ________  
(Enter whole numbers only (no text).)

Mode of Delivery:  
- Normal Vaginal Delivery  
- Ventouse/Forceps Delivery  
- Elective/Planned Caesarean Section  
- Emergency/Unplanned Caesarean Section

Caesarean Section Information:

Indication(s) for Elective Caesarean Section: ________________________________

Indication(s) for Emergency Caesarean Section:  
- Fetal Distress  
- Failure to Progress in First Stage  
- Failure to Progress in Second Stage  
- Other
Other Indication(s) for Emergency Caesarean Section (if not listed above): 

Estimated Blood Loss at Delivery: 

(Estimate in millilitres. Enter numbers only (no text).)

Diagnosis of IPFDs or IPNDs: 

- known
- unknown

Prophylactic haemostatic cover used during labour and delivery: 

- Antifibrinolytics (eg. Tranexamic Acid)
- Desmopression (DDAVP)
- Platelet transfusion
- Other products (specify)
- No prophylactic haemostatic cover (state reason): (Please check all that apply.)

Please specify other products used: 

Please state reason for no prophylactic haemostatic cover used: 

Prophylactic haemostatic cover used during postnatal period: 

- Antifibrinolytics (eg. Tranexamic Acid)
- Desmopression (DDAVP)
- Platelet transfusion
- Other products (specify)
- No prophylactic haemostatic cover (state reason): (Please check all that apply.)

Please specify other products: 

Please state reason for not having haemostatic cover: 

Postpartum Haemorrhage (PPH): 

PPH present? 

- Yes
- No

PPH is defined as an estimated total blood loss >= 500 mLs.

Total Blood Loss Documented: 

(Estimate in millilitres. Enter numbers only (no text).)

How did PPH present? 

- Primary (< =24 hours after delivery)
- Secondary (> 24 hours after deliver) (Please check all that apply.)
## Attributed Cause(s) of Primary PPH (if known):

---

### Treatment for Primary PPH:
- [ ] No treatment needed.
- [ ] Desmopressin (DDAVP)
- [ ] Platelet transfusion.
- [ ] Antifibrinolytics eg Tranexamic Acid
- [ ] Packed red cells transfusion.
- [ ] Other blood products transfusion.
- [ ] Uterotonics (oxytocics/syntocinon, ergometrine, carboprost, misoprostol)
- [ ] Balloon tamponade e.g. Bakri balloon
- [ ] Burch compression suture
- [ ] Uterine artery embolization / uterine or iliac artery ligation
- [ ] Hysterectomy
- [x] Other treatment given.

(please check all that apply.)

### Units of Platelets Needed:

(Enter number of units given)

### Units of Packed Red Cells Needed:

(Enter number of units given)

### Additional Information Regarding Other Blood Product Transfusion:

---

### Specify Other Treatment Given (if not listed above):

---

### Need for HDU/ITU admission due to primary PPH?
- [ ] Yes
- [x] No

### Number of days of hospital admission before discharge:

(Enter whole numbers only (no text).)

### Attributed Cause(s) of Secondary PPH (if known):

---
### Treatment for secondary PPH:

- No treatment needed.
- Desmopressin (DDAVP)
- Platelet transfusion.
- Antifibrinolytics eg Tranexamic Acid
- Packed red cells transfusion.
- Other blood products transfusion.
- Uterotonics (oxytocics/syntocinon, ergometrine, carboprost, misoprostol)
- Balloon tamponade e.g. Bakri balloon
- Burch compression suture
- Uterine artery embolization / uterine or iliac artery ligation
- Hysterectomy
- Other treatment given.

(Please check all that apply.)

---

### Units of platelets needed:

(Enter number of units given)

---

### Number of Units of Packed Red Cells Needed:

(Enter number of units given)

---

### Additional Information Regarding Other Blood Product Transfusion:

---

### Specify other treatment given:

---

### Need for HDU/ITU admission due to secondary PPH?

- Yes
- No

---

### Number of days of hospital admission before discharge:

(Enter whole numbers only (no text).)

---

### Regional Analgesia or Anaesthesia One

- Was regional analgesia or anaesthesia (epidural or spinal) used during labour, delivery or postnatal period?
  - Yes
  - No

---

- Did spinal haematoma occur?
  - Yes
  - No

---

Give details on any prophylactic haemostatic cover used for this procedure and mention any complications:

---
**Neonate One**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex:</td>
<td>Male, Female</td>
</tr>
<tr>
<td>Weight Units:</td>
<td>Kilograms (kg), Pounds (lbs.oz)</td>
</tr>
<tr>
<td>Weight Quantity:</td>
<td>(Enter numbers only (no text).)</td>
</tr>
<tr>
<td>Neonatal Intensive Care Admission:</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Reason for Admission:</td>
<td></td>
</tr>
<tr>
<td>Duration of Stay in NICU:</td>
<td></td>
</tr>
<tr>
<td>Any bleeding complications (e.g. bleeding from umbilicus, cephalohaematoma, intracranial haemorrhage (please specify details))?</td>
<td></td>
</tr>
<tr>
<td>Did the baby have NAIT (Neonatal Alloimmune thrombocytopenia)?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Please give more information (e.g. clinical presentation, platelet count, type of maternal antibodies implicated, management and clinical outcome of baby):</td>
<td></td>
</tr>
<tr>
<td>Does the baby or child have IPFDs or IPNDs?</td>
<td>Yes, No, Unknown</td>
</tr>
<tr>
<td>What treatment was received for the baby/child's platelet function disorder?</td>
<td></td>
</tr>
</tbody>
</table>

**Pregnancy Two**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of Pregnancy:</td>
<td></td>
</tr>
<tr>
<td>Bleeding in early pregnancy?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>How much early bleeding occurred (EBL/Quantify)?</td>
<td></td>
</tr>
</tbody>
</table>
| Haemostatic treatment given for early pregnancy bleeding: | ☐ Antifibrinolytic agent eg Tranexamic Acid  
☐ Desmopressin (DDAVP)  
☐ Platelet transfusion  
☐ Other products (specify below)  
☐ No haemostatic treatment - diagnosis of platelet function disorder known (state reason)  
☐ No haemostatic treatment - diagnosis of platelet function disorder unknown (Please check all that apply.) |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Please specify other products:</td>
</tr>
<tr>
<td>Please state the reason for no haemostatic treatment - diagnosis of platelet function disorder known:</td>
</tr>
</tbody>
</table>
| Antepartum haemorrhage (bleeding after 24 weeks)?             | ☐ Yes  
☐ No |
| How much antepartum haemorrhage (bleeding after 24 weeks) occurred (EBL/Quantify)? | ____________________________________ |
| Haemostatic treatment given for APH:                         | ☐ Antifibrinolytic agent eg Tranexamic Acid  
☐ Desmopressin (DDAVP)  
☐ Platelet transfusion  
☐ Other products (specify below)  
☐ No haemostatic treatment - diagnosis of platelet function disorder known (state reason)  
☐ No haemostatic treatment - diagnosis of platelet function disorder unknown (Please check all that apply.) |
| Please specify other products:                                | ____________________________________ |
| Please state reason for no haemostatic treatment - diagnosis of platelet function disorder known: | ____________________________________ |
| Presence of Pre-Eclampsia (PET)?                             | ☐ Yes  
☐ No |
| Pre-eclampsia is defined as high blood pressure >= 140/90 with significant proteinuria of >= 300mg in 24 hr urine (or significant alternate proteinuria quantification e.g. urine PCR >= 30 or urine dipstick >= 1+) after 20 weeks of pregnancy. |  |
| Provide the following details regarding positive pre-eclampsia diagnosis. |  |
| Review the attached document below to classify the severity of Pre-eclampsia: | [Attachment: "Classification of PET severity.pdf"]  |
| State severity of PET:                                       | ☐ Mild  
☐ Moderate  
☐ Severe |
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platelet Count:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HELLP Syndrome:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, please give more information on clinical course, investigations including haemoglobin, liver enzymes and management:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence of small for gestational age or intrauterine growth restriction?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was antiplatelet antibody tested in this pregnancy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the result positive or negative?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please specify the type and titre if known:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the mother require referral to fetal medicine for monitoring?</td>
<td></td>
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<tr>
<td>Did she require IVIG treatment?</td>
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</tr>
<tr>
<td>Did the baby require in-utero platelet transfusion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the mother delivered preterm because of NAIT (Neonatal Alloimmune thrombocytopenia)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Delivery Two**

Gestational Age at Delivery (weeks):

(Enter whole numbers only (no text).)

Mode of Delivery:

- Normal Vaginal Delivery
- Ventouse/Forceps Delivery
- Elective/Planned Caesarean Section
- Emergency/Unplanned Caesarean Section

Caesarean Section Information:

Indication(s) for Elective Caesarean Section:

Indication(s) for Emergency Caesarean Section:

- Fetal Distress
- Failure to Progress in First Stage
- Failure to Progress in Second Stage
- Other
### Other Indication(s) for Emergency Caesarean Section
(If not listed above):

|____________________________________________|

### Estimated Blood Loss at Delivery:

|____________________________________________|

(Enter in millilitres. Enter numbers only (no text).)

### Diagnosis of IPFDs or IPNDs:

- [ ] known
- [ ] unknown

### Prophylactic haemostatic cover used during labour and delivery:

- [ ] Antifibrinolytics (eg. Tranexamic Acid)
- [ ] Desmopression (DDAVP)
- [ ] Platelet transfusion
- [ ] Other products (specify)
- [ ] No prophylactic haemostatic cover (state reason):

(Please check all that apply.)

### Please specify other products:

|____________________________________________|

### Please state reason for no prophylactic haemostatic cover used:

|____________________________________________|

### Prophylactic haemostatic cover used postnatal period:

- [ ] Antifibrinolytics (eg. Tranexamic Acid)
- [ ] Desmopression (DDAVP)
- [ ] Platelet transfusion
- [ ] Other products (specify)
- [ ] No prophylactic haemostatic cover (state reason):

(Please check all that apply.)

### Specify other products:

|____________________________________________|

### Please state reason for not having haemostatic cover:

|____________________________________________|

### Postpartum Haemorrhage (PPH):

| PPH present? | Yes | No |

PPH is defined as an estimated total blood loss >= 500 mLs.

### Total Blood Loss Documented:

|____________________________________________|

(Enter in millilitres. Enter numbers only (no text).)

### How did PPH present?

- [ ] Primary (< = 24 hours after delivery)
- [ ] Secondary (> 24 hours after delivery)

(Please check all that apply.)
Attributed Cause(s) of Primary PPH (if known):

<table>
<thead>
<tr>
<th>Treatment for Primary PPH:</th>
<th>☐ No treatment needed.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Desmopressin (DDAVP)</td>
</tr>
<tr>
<td></td>
<td>☐ Platelet transfusion.</td>
</tr>
<tr>
<td></td>
<td>☐ Antifibrinolytics eg Tranexamic Acid</td>
</tr>
<tr>
<td></td>
<td>☐ Packed red cells transfusion.</td>
</tr>
<tr>
<td></td>
<td>☐ Other blood products transfusion.</td>
</tr>
<tr>
<td></td>
<td>☐ Uterotonics (oxytocics/syntocinon, ergometrine, carboprost, misoprostol)</td>
</tr>
<tr>
<td></td>
<td>☐ Balloon tamponade e.g. Bakri balloon</td>
</tr>
<tr>
<td></td>
<td>☐ Burch compression suture</td>
</tr>
<tr>
<td></td>
<td>☐ Uterine artery embolization / uterine or iliac artery ligation</td>
</tr>
<tr>
<td></td>
<td>☐ Hysterectomy</td>
</tr>
<tr>
<td></td>
<td>☐ Other treatment given.</td>
</tr>
</tbody>
</table>

(Please check all that apply.)

<table>
<thead>
<tr>
<th>Units of Platelets Needed:</th>
<th>__________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Enter number of units given)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Units of Packed Red Cells Needed:</th>
<th>__________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Enter number of units given)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Information Regarding Other Blood Product Transfusion:</th>
<th>__________________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Specify Other Treatment Given (if not listed above):</th>
<th>__________________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Need for HDU/ITU admission due to primary PPH?</th>
<th>☐ Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of days of hospital admission before discharge:</th>
<th>__________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Enter whole numbers only (no text).)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attributed Cause(s) of Secondary PPH (if known):</th>
<th>__________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of Secondary PPH:</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td></td>
</tr>
<tr>
<td>☐ No treatment needed.</td>
<td></td>
</tr>
<tr>
<td>☐ Desmopressin (DDAVP) concentrate</td>
<td></td>
</tr>
<tr>
<td>☐ Platelet transfusion.</td>
<td></td>
</tr>
<tr>
<td>☐ Antifibrinolytics eg Tranexamic Acid</td>
<td></td>
</tr>
<tr>
<td>☐ Packed red cells transfusion.</td>
<td></td>
</tr>
<tr>
<td>☐ Other blood products transfusion.</td>
<td></td>
</tr>
<tr>
<td>☐ Uterotonics (oxytocics/syntocinon, ergometrine, carboprost, misoprostol)</td>
<td></td>
</tr>
<tr>
<td>☐ Balloon tamponade e.g. Bakri balloon</td>
<td></td>
</tr>
<tr>
<td>☐ Burch compression suture</td>
<td></td>
</tr>
<tr>
<td>☐ Uterine artery embolization / uterine or iliac artery ligation</td>
<td></td>
</tr>
<tr>
<td>☐ Hysterectomy</td>
<td></td>
</tr>
<tr>
<td>☐ Other treatment given.</td>
<td></td>
</tr>
<tr>
<td>(Please check all that apply.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Units of platelets needed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Enter number of units given)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Units of Packed Red Cells Needed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Enter number of units given)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Information Regarding Other Blood Product Transfusion:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specify other treatment given:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Need for HDU/ITU admission due to secondary PPH?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of days of hospital admission before discharge:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Enter whole numbers only (no text).)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regional Analgesia or Anaesthesia Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was regional analgesia or anaesthesia (epidural or spinal) used during labour, delivery or postnatal period?</td>
</tr>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did spinal haematoma occur?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Give details on any prophylactic haemostatic cover used for this procedure and mention any complications:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
### Neonate Two

<table>
<thead>
<tr>
<th>Question</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex:</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Weight Units:</td>
<td>Kilograms (kg)</td>
<td>Pounds (lbs.oz)</td>
</tr>
<tr>
<td>Weight Quantity:</td>
<td>(Enter numbers only (no text).)</td>
<td></td>
</tr>
<tr>
<td>Neonatal Intensive Care Admission:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Reason for Admission:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of Stay in NICU:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any bleeding complications (e.g. bleeding from umbilicus, cephalohaematoma, intracranial haemorrhage (please specify details)?)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the baby have NAIT (Neonatal Alloimmune thrombocytopenia)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Please give more information (e.g. clinical presentation, platelet count, type of maternal antibodies implicated, management and clinical outcome of baby):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the baby or child have IPFDs or IPNDs?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>What treatment was received for the baby/child's platelet function disorder?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Pregnancy Three

<table>
<thead>
<tr>
<th>Question</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of Pregnancy:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding in early pregnancy?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>How much early bleeding occurred (EBL/Quantify)?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Haemostatic treatment given for early pregnancy bleeding: | □ Antifibrinolytic agent eg Tranexamic Acid  
□ Desmopressin (DDAVP)  
□ Platelet transfusion  
□ Other products (specify below)  
□ No haemostatic treatment - diagnosis of platelet function disorder known (state reason)  
□ No haemostatic treatment - diagnosis of platelet function disorder unknown (Please check all that apply.) |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Please specify other products:</td>
</tr>
<tr>
<td>Please state reason for no haemostatic treatment - diagnosis of platelet function disorder known:</td>
</tr>
</tbody>
</table>
| Antepartum haemorrhage (bleeding after 24 weeks)? | □ Yes  
□ No |
| How much antepartum haemorrhage (bleeding after 24 weeks) occurred (EBL/Quantify)? | __________________________ |
| Haemostatic treatment given for APH: | □ Antifibrinolytic agent eg Tranexamic Acid  
□ Desmopressin (DDAVP)  
□ Platelet transfusion  
□ Other products (specify below)  
□ No haemostatic treatment - diagnosis of platelet function disorder known (state reason)  
□ No haemostatic treatment - diagnosis of platelet function disorder unknown (Please check all that apply.) |
| Please specify other products: | __________________________ |
| Please state reason for no haemostatic treatment - diagnosis of platelet function disorder known: | __________________________ |
| Presence of Pre-Eclampsia (PET)? | □ Yes  
□ No |
| Pre-eclampsia is defined as high blood pressure >= 140/90 with significant proteinuria of >= 300mg in 24 hr urine (or significant alternate proteinuria quantification e.g. urine PCR >= 30 or urine dipstick >= 1+) after 20 weeks of pregnancy. |
| Provide the following details regarding positive pre-eclampsia diagnosis. |
| Review the attached document below to classify the severity of Pre-eclampsia: |
| [Attachment: "Classification of PET severity.pdf"] |
| State severity of PET: | □ Mild  
□ Moderate  
□ Severe |
Platelet Count: ____________________________________

HELLP Syndrome:  
- Yes  
- No

If Yes, please give more information on clinical course, investigations including haemoglobin, liver enzymes and management:

Presence of small for gestational age or intrauterine growth restriction:  
- Yes  
- No

Was antiplatelet antibody tested in this pregnancy:  
- Yes  
- No

Was the result positive or negative:  
- Positive  
- Negative

Please specify the type and titre if known: ____________________________________

Did the mother require referral to fetal medicine for monitoring:  
- Yes  
- No

Did she require IVIG treatment:  
- Yes  
- No

Did the baby require in-utero platelet transfusion:  
- Yes  
- No

Was the mother delivered preterm because of NAIT (Neonatal Alloimmune thrombocytopenia):  
- Yes  
- No

## Delivery Three

Gestational Age at Delivery (weeks):  
(Enter whole numbers only (no text).)

Mode of Delivery:  
- Normal Vaginal Delivery  
- Ventouse/Forceps Delivery  
- Elective/Planned Caesarean Section  
- Emergency/Unplanned Caesarean Section

Caesarean Section Information

Indication(s) for Elective Caesarean Section: ____________________________________

Indication(s) for Emergency Caesarean Section:  
- Fetal Distress  
- Failure to Progress in First Stage  
- Failure to Progress in Second Stage  
- Other
Other Indication(s) for Emergency Caesarean Section (if not listed above):

---

Estimated Blood Loss at Delivery:

(Estimate in millilitres. Enter numbers only (no text).)

---

Diagnosis of IPFDs or IPNDs:

- [ ] known
- [ ] unknown

---

Type of prophylactic haemostatic cover used during labour and delivery:

- [ ] Antifibrinolytics (eg. Tranexamic Acid)
- [ ] Desmopression (DDAVP)
- [ ] Platelet transfusion
- [ ] Other products (specify)
- [ ] No prophylactic haemostatic cover (state reason):

(Please check all that apply.)

---

Please specify other products used:

---

Please state the reason for no prophylactic haemostatic cover:

---

Type of prophylactic haemostatic cover used during postnatal period?

- [ ] Antifibrinolytics (eg. Tranexamic Acid)
- [ ] Desmopression (DDAVP)
- [ ] Platelet transfusion
- [ ] Other products (specify)
- [ ] No prophylactic haemostatic cover (state reason):

(Please check all that apply.)

---

Please specify other products:

---

Please state reason for not having haemostatic cover:

---

Postpartum Haemorrhage (PPH)

---

PPH present?

- [ ] Yes
- [ ] No

---

PPH is defined as an estimated total blood loss >= 500 mLs.

---

Total Blood Loss Documented:

(Estimate in millilitres. Enter numbers only (no text.).)

---

How did PPH present?

- [ ] Primary (< = 24 hours after delivery)
- [ ] Secondary (> 24 hours after delivery)

(Please check all that apply.)
Attributed Cause(s) of Primary PPH (if known):

<table>
<thead>
<tr>
<th>Treatment for Primary PPH:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No treatment needed.</td>
</tr>
<tr>
<td>☐ Desmopressin (DDAVP) concentrate</td>
</tr>
<tr>
<td>☐ Platelet transfusion.</td>
</tr>
<tr>
<td>☐ Antifibrinolytics eg Tranexamic Acid</td>
</tr>
<tr>
<td>☐ Packed red cells transfusion.</td>
</tr>
<tr>
<td>☐ Other blood products transfusion.</td>
</tr>
<tr>
<td>☐ Uterotonics (oxytocics/syntocinon, ergometrine, carmust, misoprostol)</td>
</tr>
<tr>
<td>☐ Balloon tamponade e.g. Bakri balloon</td>
</tr>
<tr>
<td>☐ Burch compression suture</td>
</tr>
<tr>
<td>☐ Uterine artery embolization / uterine or iliac artery ligation</td>
</tr>
<tr>
<td>☐ Hysterectomy</td>
</tr>
<tr>
<td>☐ Other treatment given.</td>
</tr>
</tbody>
</table>

(Please check all that apply.)

Units of Platelets Needed:

(Enter number of units given)

Units of Packed Red Cells Needed:

(Enter number of units given)

Additional Information Regarding Other Blood Product Transfusion:

Specify Other Treatment Given (if not listed above):

Need for HDU/ITU admission due to primary PPH?

☐ Yes

☐ No

Number of days of hospital admission before discharge:

(Enter whole numbers only (no text).)

Attributed Cause(s) of Secondary PPH (if known):

__________________________________
### Treatment for Secondary PPH:

- No treatment needed.
- Desmopressin (DDAVP)
- Platelet transfusion.
- Antifibrinolytics eg Tranexamic Acid
- Packed red cells transfusion.
- Other blood products transfusion.
- Uterotonics (oxytocics/syntocinon, ergometrine, carboprost, misoprostol)
- Balloon tamponade e.g. Bakri balloon
- Burch compression suture
- Uterine artery embolization / uterine or iliac artery ligation
- Hysterectomy
- Other treatment given.

(Please check all that apply.)

### Units of Platelets Needed:

(Enter number of units given)

### Units of Packed Red Cells Needed:

(Enter number of units given)

### Additional Information Regarding Other Blood Product Transfusion:

Specify other treatment given (if not listed above):

### HDU/ITU admission due to secondary PPH?

- Yes
- No

### Number of days of hospital admission before discharge:

(Enter whole numbers only (no text).)

### Regional Analgesia or Anaesthesia Three

- Was regional analgesia or anaesthesia (epidural or spinal) used during labour, delivery or postnatal period? 
  - Yes
  - No

- Did spinal haematoma occur?
  - Yes
  - No

Give details on any prophylactic haemostatic cover used for this procedure and mention any complications:
### Neonate Three

| Sex: | ○ Male  
<table>
<thead>
<tr>
<th></th>
<th>○ Female</th>
</tr>
</thead>
</table>
| Weight Units: | ○ Kilograms (kg)  
|  | ○ Pounds (lbs.oz) |
| Weight Quantity: | (Enter numbers only (no text).) |
| Neonatal Intensive Care Admission: | ○ Yes  
|  | ○ No |
| Reason for Admission: | |
| Duration of Stay in NICU: | |
| Any bleeding complications (e.g. bleeding from umbilicus, cephalohaematoma, intracranial haemorrhage (please specify details)?: | |
| Did the baby have NAIT (Neonatal Alloimmune thrombocytopenia)? | ○ Yes  
|  | ○ No |
| Please give more information (e.g. clinical presentation, platelet count, type of maternal antibodies implicated, management and clinical outcome of baby): | |
| Does the baby or child have IPFDs or IPNDs? | ○ Yes  
|  | ○ No  
|  | ○ Unknown |
| What treatment was received for the baby/child's platelet function disorder? | |

### Pregnancy Four

<table>
<thead>
<tr>
<th>Year of Pregnancy:</th>
<th></th>
</tr>
</thead>
</table>
| Bleeding in early pregnancy? | ○ Yes  
|  | ○ No |
| How much early bleeding occurred (EBL/Quantify)? | |
### Haemostatic treatment given for early pregnancy bleeding:

- [ ] Antifibrinolytic agent eg Tranexamic Acid
- [ ] Desmopressin (DDAVP)
- [ ] Platelet transfusion
- [ ] Other products (specify below)
- [ ] No haemostatic treatment - diagnosis of platelet function disorder known (state reason)
- [ ] No haemostatic treatment - diagnosis of platelet function disorder unknown (Please check all that apply.)

Please specify other products:

---

Please state reason for no haemostatic treatment - diagnosis of platelet function disorder known:

---

### Antepartum haemorrhage (bleeding after 24 weeks)?

- [ ] Yes
- [ ] No

### How much antepartum haemorrhage (bleeding after 24 weeks) occurred (EBL/Quatify)?

---

### Haemostatic treatment given for APH:

- [ ] Antifibrinolytic agent eg Tranexamic Acid
- [ ] Desmopressin (DDAVP)
- [ ] Platelet transfusion
- [ ] Other products (specify below)
- [ ] No haemostatic treatment - diagnosis of platelet function disorder known (state reason)
- [ ] No haemostatic treatment - diagnosis of platelet function disorder unknown (Please check all that apply.)

Please specify other products:

---

Please state reason for no haemostatic treatment - diagnosis of platelet function disorder known:

---

### Presence of Pre-Eclampsia (PET)?

- [ ] Yes
- [ ] No

Pre-eclampsia is defined as high blood pressure >= 140/90 with significant proteinuria of >= 300mg in 24 hr urine (or significant alternate proteinuria quantification e.g. urine PCR >= 30 or urine dipstick >= 1+) after 20 weeks of pregnancy.

Provide the following details regarding positive pre-eclampsia diagnosis.

Review the attached document below to classify the severity of Pre-eclampsia:

[Attachment: "Classification of PET severity.pdf"]

State severity of PET:

- [ ] Mild
- [ ] Moderate
- [ ] Severe
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Platelet Count:</td>
<td></td>
</tr>
<tr>
<td>HELLP Syndrome:</td>
<td></td>
</tr>
<tr>
<td>If Yes, please give more information on clinical course, investigations</td>
<td></td>
</tr>
<tr>
<td>including haemoglobin, liver enzymes and management:</td>
<td></td>
</tr>
<tr>
<td>Presence of small for gestational age or intrauterine</td>
<td></td>
</tr>
<tr>
<td>growth restriction?</td>
<td></td>
</tr>
<tr>
<td>Was antiplatelet antibody tested in this pregnancy?</td>
<td></td>
</tr>
<tr>
<td>Was the result positive or negative?</td>
<td></td>
</tr>
<tr>
<td>Please specify the type and titre if known:</td>
<td></td>
</tr>
<tr>
<td>Did the mother require referral to fetal medicine for monitoring?</td>
<td></td>
</tr>
<tr>
<td>Did she require IVIG treatment?</td>
<td></td>
</tr>
<tr>
<td>Did the baby require in-utero platelet transfusion?</td>
<td></td>
</tr>
<tr>
<td>Was the mother delivered preterm because of NAIT</td>
<td></td>
</tr>
<tr>
<td>(Neonatal Alloimmune thrombocytopenia)?</td>
<td></td>
</tr>
<tr>
<td><strong>Delivery Four</strong></td>
<td></td>
</tr>
<tr>
<td>Gestational Age at Delivery (weeks):</td>
<td>(Enter whole numbers only (no text).)</td>
</tr>
<tr>
<td>MODE OF DELIVERY:</td>
<td></td>
</tr>
<tr>
<td>Normal Vaginal Delivery</td>
<td></td>
</tr>
<tr>
<td>Ventouse/Forceps Delivery</td>
<td></td>
</tr>
<tr>
<td>Elective/Planned Caesarean Section</td>
<td></td>
</tr>
<tr>
<td>Emergency/Unplanned Caesarean Section</td>
<td></td>
</tr>
<tr>
<td>Caesarean Section Information</td>
<td></td>
</tr>
<tr>
<td>Indication(s) for Elective Caesarean Section:</td>
<td></td>
</tr>
<tr>
<td>Indication(s) for Emergency Caesarean Section:</td>
<td></td>
</tr>
<tr>
<td>Fetal Distress</td>
<td></td>
</tr>
<tr>
<td>Failure to Progress in First Stage</td>
<td></td>
</tr>
<tr>
<td>Failure to Progress in Second Stage</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
### Other Indication(s) for Emergency Caesarean Section (if not listed above):


### Estimated Blood Loss at Delivery:

(Enter numbers only (no text)).

### Diagnosis of IPFDs or IPNDs:

- [ ] known
- [ ] unknown

### Prophylactic haemostatic cover used during labour and delivery:

- [ ] Antifibrinolytics (eg. Tranexamic Acid)
- [ ] Desmopression (DDAVP)
- [ ] Platelet transfusion
- [ ] Other products (specify)
- [ ] No prophylactic haemostatic cover (state reason):
  (Please check all that apply.)

Please specify other products used:


Please state the reason for no prophylactic haemostatic cover used:


### Prophylactic haemostatic cover used during postnatal period?

- [ ] Antifibrinolytics (eg. Tranexamic Acid)
- [ ] Desmopression (DDAVP)
- [ ] Platelet transfusion
- [ ] Other products (specify)
- [ ] No prophylactic haemostatic cover (state reason):
  (Please check all that apply.)

Specify other products:


Please state reason for not having haemostatic cover:


### Postpartum Haemorrhage (PPH)

**PPH present?**

- [ ] Yes
- [ ] No

PPH is defined as an estimated total blood loss >= 500 mLs.

Total Blood Loss Documented:

(Estimate in millilitres. Enter numbers only (no text)).

How did PPH present?

- [ ] Primary (<= 24 hours after delivery)
- [ ] Secondary (> 24 hours after deliver)
  (Please check all that apply.)

Attributed Cause(s) of Primary PPH (if known):
### Treatment for Primary PPH:

- No treatment needed.
- Desmopressin (DDAVP) concentrate
- Platelet transfusion.
- Antifibrinolytics eg Tranexamic Acid
- Packed red cells transfusion.
- Other blood products transfusion.
- Uterotonics (oxytocics/syntocinon, ergometrine, carboprost, misoprostol)
- Balloon tamponade e.g. Bakri balloon
- Burch compression suture
- Uterine artery embolization / uterine or iliac artery ligation
- Hysterectomy
- Other treatment given.

(Please check all that apply.)

### Units of Platelets Needed:

(Enter number of units given)

### Units of Packed Red Cells Needed:

(Enter number of units given)

### Additional Information Regarding Other Blood Product Transfusion:

### Specify Other Treatment Given (if not listed above):

### Need for HDU/ITU admission due to primary PPH?

- Yes
- No

### Number of days of hospital admission before discharge:

(Enter whole numbers only (no text).)

### Attributed Cause(s) of Secondary PPH (if known):

### Attributed Cause(s) of Secondary PPH (if known):

- No treatment needed.
- Desmopressin (DDAVP) concentrate
- Platelet transfusion.
- Antifibrinolytics eg Tranexamic Acid
- Packed red cells transfusion.
- Other blood products transfusion.
- Uterotonics (oxytocics/syntocinon, ergometrine, carboprost, misoprostol)
- Balloon tamponade e.g. Bakri balloon
- Burch compression suture
- Uterine artery embolization / uterine or iliac artery ligation
- Hysterectomy
- Other treatment given.

(Please check all that apply.)
Units of platelets needed: ____________________________
(Enter number of units given)

Number of Units of Packed Red Cells Needed: ____________________________
(Enter number of units given)

Additional Information Regarding Other Blood Product Transfusion: __________

Specify other treatment given: __________

HDU/ITU admission due to secondary PPH?
☐ Yes
☐ No

Number of days of hospital admission before discharge:
(Enter whole numbers only (no text).)

Regional Analgesia or Anaesthesia Four

Was regional analgesia or anaesthesia (epidural or spinal) used during labour, delivery or postnatal period?
☐ Yes
☐ No

Did spinal haematomata occur?
☐ Yes
☐ No

Give details on any prophylactic haemostatic cover used for this procedure and mention any complications:

Neonate Four

Sex: 
☐ Male
☐ Female

Weight Units: 
☐ Kilograms (kg)
☐ Pounds (lbs.oz)

Weight Quantity:
(Enter numbers only (no text).)

Neonatal Intensive Care Admission:
☐ Yes
☐ No

Reason for Admission: __________

Duration of Stay in NICU: __________
Any bleeding complications (e.g. bleeding from umbilicus, cephalohaematoma, intracranial haemorrhage (please specify details)?

Did the baby have NAIT (Neonatal Alloimmune thrombocytopenia)?
- Yes
- No

Please give more information (e.g. clinical presentation, platelet count, type of maternal antibodies implicated, management and clinical outcome of baby):

Does the baby or child have IPFDs or IPNDs?
- Yes
- No
- Unknown

What treatment was received for the baby/child's platelet function disorder?

Pregnancy Five

Year of Pregnancy:

Bleeding in early pregnancy?
- Yes
- No

How much early bleeding occurred (EBL/Quantify)?

Haemostatic treatment given for early pregnancy bleeding:
- Antifibrinolytic agent eg Tranexamic Acid
- Desmopressin (DDAVP)
- Platelet transfusion
- Other products (specify below)
- No haemostatic treatment - diagnosis of platelet function disorder known (state reason)
- No haemostatic treatment - diagnosis of platelet function disorder unknown (Please check all that apply.)

Please specify other products:

Please state reason for no haemostatic treatment - diagnosis of platelet function disorder known:

Antepartum haemorrhage (bleeding after 24 weeks)?
- Yes
- No

How much antepartum haemorrhage (bleeding after 24 weeks) occurred (EBL/Quatify)?
Haemostatic treatment given for APH:

- Antifibrinolytic agent eg Tranexamic Acid
- Desmopressin (DDAVP)
- Platelet transfusion
- Other products (specify below)
- No haemostatic treatment - diagnosis of platelet function disorder known (state reason)
- No haemostatic treatment - diagnosis of platelet function disorder unknown (Please check all that apply)

Please specify other product given:

__________________________________

Please state reason for no haemostatic treatment - diagnosis of platelet function disorder known:

__________________________________

Presence of Pre-Eclampsia (PET)?

- Yes
- No

Pre-eclampsia is defined as high blood pressure >= 140/90 with significant proteinuria of >= 300mg in 24 hr urine (or significant alternate proteinuria quantification e.g. urine PCR >= 30 or urine dipstick >= 1+) after 20 weeks of pregnancy.

Provide the following details regarding positive pre-eclampsia diagnosis.

Review the attached document below to classify the severity of Pre-eclampsia:

[Attachment: "Classification of PET severity.pdf"]

State severity of PET:

- Mild
- Moderate
- Severe

Platelet Count:

__________________________________

HELLP Syndrome:

- Yes
- No

If Yes, please give more information on clinical course, investigations including haemoglobin, liver enzymes and management:

__________________________________

Presence of small for gestational age or intrauterine growth restriction?

- Yes
- No

Was antiplatelet antibody tested in this pregnancy?

- Yes
- No

Was the result positive or negative?

- Positive
- Negative

Please specify the type and titre if known:

__________________________________
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the mother require referral to fetal medicine for monitoring?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did she require IVIG treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the baby require in-utero platelet transfusion?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the mother delivered preterm because of NAIT (Neonatal Alloimmune thrombocytopenia)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Delivery Five**

Gestational Age at Delivery (weeks):

(Enter whole numbers only (no text).)

Mode of Delivery:

- Normal Vaginal Delivery
- Ventouse/Forceps Delivery
- Elective/Planned Caesarean Section
- Emergency/Unplanned Caesarean Section

**Caesarean Section Information**

Indication(s) for Elective Caesarean Section:

Indication(s) for Emergency Caesarean Section:

- Fetal Distress
- Failure to Progress in First Stage
- Failure to Progress in Second Stage
- Other

Other Indication(s) for Emergency Caesarean Section (if not listed above):

Estimated Blood Loss at Delivery:

(Estimate in millilitres. Enter numbers only (no text).)

Diagnosis of IPFDs or IPNDs:

- known
- unknown

Prophylactic haemostatic cover used during labour and delivery:

- Antifibrinolytics (eg. Tranexamic Acid)
- Desmopressin (DDAVP)
- Platelet transfusion
- Other products (specify)
- No prophylactic haemostatic cover (state reason): (Please check all that apply.)

Please specify other products:

Please state reason for no prophylactic haemostatic cover:

____________________________________
<table>
<thead>
<tr>
<th>Type of prophylactic haemostatic cover used during postnatal period:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Antifibrinolytics eg Tranexamic Acid</td>
</tr>
<tr>
<td>☐ Desmopressin (DDAVP)</td>
</tr>
<tr>
<td>☐ Platelet transfusion</td>
</tr>
<tr>
<td>☐ Other products (specify)</td>
</tr>
<tr>
<td>☐ No prophylactic haemostatic cover (state reason): (Please check all that apply.)</td>
</tr>
</tbody>
</table>

Specify other products: 

Please state reason for not having haemostatic cover: 

Postpartum Haemorrhage (PPH)

PPH present?  
☐ Yes  ☐ No

PPH is defined as an estimated total blood loss ≥ 500 mLs.

Total Blood Loss Documented: 

(Estimate in millilitres. Enter numbers only (no text.).)

How did PPH present?  
☐ Primary (< = 24 hours after delivery)  ☐ Secondary (> 24 hours after delivery)  (Please check all that apply.)

Attributed Cause(s) of Primary PPH (if known):  

Treatment for Primary PPH:  
☐ No treatment needed.  ☐ Desmopressin (DDAVP)  ☐ Platelet transfusion.  ☐ Antifibrinolytics eg Tranexamic Acid  ☐ Packed red cells transfusion.  ☐ Other blood products transfusion.  ☐ Uterotonics (oxytocics/syntocinon, ergometrine, carboprost, misoprostol)  ☐ Balloon tamponade e.g. Bakri balloon  ☐ Burch compression suture  ☐ Uterine artery embolization / uterine or iliac artery ligation  ☐ Hysterectomy  ☐ Other treatment given.  (Please check all that apply.)

Units of Platelets Needed: 

(Enter number of units given)

Units of Packed Red Cells Needed: 

(Enter number of units given)
### Additional Information Regarding Other Blood Product Transfusion:

Specify Other Treatment Given (if not listed above):

Need for HDU/ITU admission due to primary PPH?
- [ ] Yes
- [x] No

Number of days of hospital admission before discharge:

Attributed Cause(s) of Secondary PPH (if known):

### Treatment for Secondary PPH:

- [ ] No treatment needed.
- [ ] Desmopressin (DDAVP)
- [ ] Platelet transfusion.
- [ ] Antifibrinolytics eg Tranexamic Acid
- [ ] Packed red cells transfusion.
- [ ] Other blood products transfusion.
- [ ] Uterotonicus (oxytocics/syntocinon, ergometrine, carboprost, misoprostol)
- [ ] Balloon tamponade e.g. Bakri balloon
- [ ] Burch compression suture
- [ ] Uterine artery embolization / uterine or iliac artery ligation
- [ ] Hysterectomy
- [ ] Other treatment given.

(Please check all that apply.)

Units of platelets needed:

Number of Units of Packed Red Cells Needed:

Additional Information Regarding Other Blood Product Transfusion:

Specify other treatment given:

Need for HDU/ITU admission due to secondary PPH?
- [ ] Yes
- [x] No

Number of days of hospital admission before discharge:

(Enter whole numbers only (no text).)
Regional Analgesia or Anaesthesia Five

Was regional analgesia or anaesthesia (epidural or spinal) used during labour, delivery or postnatal period?

☐ Yes
☐ No

Did the spinal haematoma occur?

☐ Yes
☐ No

Give details on any prophylactic haemostatic cover used for this procedure and mention any complications:

________________________________________

Neonate Five

Sex:

☐ Male
☐ Female

Weight Units:

☐ Kilograms (kg)
☐ Pounds (lbs.oz)

Weight Quantity:

(Enter numbers only (no text).)

Neonatal Intensive Care Admission:

☐ Yes
☐ No

Reason for Admission:

________________________________________

Duration of Stay in NICU:

________________________________

Any bleeding complications (e.g. bleeding from umbilicus, cephalohaematoma, intracranial haemorrhage (please specify details)?

________________________________________

Did the baby have NAIT (Neonatal Alloimmune thrombocytopenia)?

☐ Yes
☐ No

Please give more information (e.g. clinical presentation, platelet count, type of maternal antibodies implicated, management and clinical outcome of baby):

________________________________________

Does the baby or child have IPFDs or IPNDs?

☐ Yes
☐ No
☐ Unknown

What treatment was received for the baby/child's platelet function disorder?

________________________________________
### Additional Information

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did woman develop an allergic reaction or antibodies to any medication or treatment given (e.g. anti-platelet antibodies)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please provide more information:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please give additional information or comments that is not covered in questionnaire here:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>