Severe Chronic Neutropenia International Registry	**Patient ID Number**: ___/___ ___/___ ___/___ ___ ___ ___ **Patient Initials**: ___ ___ ___

PREGNANCY REPORTING

Date form completed ______ Completed by (please print) ______ Telephone ______

GENERAL INFORMATION

Patient's Name: ______________________________

Number of live births: ☐

Number of still births: ☐

Number of miscarriages or terminations: ☐

Is the patient currently pregnant? ☐ No ☐ Yes, expected date of birth: ______________

Has the patient or his/her partner experienced any fertility problem?

☐ No ☐ Yes ☐ Unknown

If yes, please describe nature of problem: ______________________________

____

____

____

Please use the back of this form to provide any additional information about patient.

Severe Chronic Neutropenia International Registry	**Patient ID Number**: ___/___ ___/___ ___/___ ___ ___ ___ **Patient Initials**: ___ ___ ___

PREGNANCY REPORTING

Date form completed ____ Completed by (please print) ____ Telephone ____

GENERAL INFORMATION *(Complete section once)*

Patient's Name: ______________________________

Primary/Secondary Medical Diagnosis: ______________________________

Number of Births: ☐ Live births ☐ Still births

Number of miscarriages or terminations: ☐ elective ☐ spontaneous ☐ mother's medical condition ☐ abnormal fetal development

Total number of pregnancies: ☐
(Add number of births and number of miscarriages/terminations.)

Currently pregnant? ☐ No ☐ Yes, expected date of birth: ____________________

PREGNANCY # __________ OUTCOME *(Complete section for each pregnancy)*

☐ Miscarriage/termination, please specify reason: ☐ elective ☐ spontaneous ☐ mother's medical condition ☐ abnormal fetal development

☐ Still birth

☐ Live birth ___/____/___ Date of birth ☐ Male ☐ Female _______ Initials

Weight: _______ Length: _______ Gestational Age: ________

☐ *Please provide copy of newborn CBC*

Complications during pregnancy (mother or baby)? ☐ No ☐ Yes, describe on back of form.

Congenital abnormalities or other medical problems (baby): ☐ No ☐ Yes, please list all abnormalities or other medical problems on back of form.

Mother nursed infant: ☐ No ☐ Yes If yes, cytokine administered to mother? ☐ No ☐ Yes

Cytokine (growth factor, e.g., G-CSF) administered during pregnancy: ☐ No ☐ Yes

If yes, indicate trimester and cytokine dose: (Circle dose units and indicate frequency.)

First, _____ ml or mcg or mcg/kg _____ freq

Second, _____ ml or mcg or mcg/kg _____ freq

Third, _____ ml or mcg or mcg/kg _____ freq

Mother's weight during pregnancy: _______ ☐ lb ☐ kg

Did patient stop cytokine treatment? ☐ No ☐ Yes, stop date: ______________________________

Please use the back of this form to provide any additional information about patient or infant.