

 health Department of Health REPUBLIC OF SOUTH AFRICA		PrEP Pregnancy Outcome Form			
First name				Folder #	
Surname				Phone #	
DOB	dd / mm / yy	Gender: M / F / TG		Address	
ID Number					
Instructions: Please use the below to capture the pregnancy outcome of mothers exposed to PrEP drugs at any time during their pregnancy. The available fields must be completed as much as possible with the relevant information available at the time of reporting. Please affix a copy of the PrEP clinical form and/or any relevant documentation.					
PrEP drugs exposure before/during pregnancy					
PrEP start date	dd / mm / yy	Time of PrEP initiation	<input type="checkbox"/> Before pregnancy	Date of positive urine test	dd / mm / yy
PrEP stop date	dd / mm / yy		<input type="checkbox"/> During pregnancy	Estimated date of delivery	dd / mm / yy
Drug name (s):			Dose: Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/> Specify:		
Pregnancy outcome					
1. Did the client experience any complication during pregnancy?		<input type="checkbox"/> Yes. Specify: <input type="checkbox"/> No			
2. Did the client give birth to (a) live infant(s)?		<input type="checkbox"/> Yes. Date of delivery: dd / mm / yy <input type="checkbox"/> No. Specify reason:			
3. Was the infant normal at birth?		<input type="checkbox"/> Yes <input type="checkbox"/> No. Specify abnormality and reason:			
4. Additional comment on pregnancy/delivery					
Infant (s) information					
Infant number	Infant sex	Infant length (cm)	Infant weight (g)	APGAR score	Comment
1	F <input type="checkbox"/> M <input type="checkbox"/>				
2	F <input type="checkbox"/> M <input type="checkbox"/>				
3	F <input type="checkbox"/> M <input type="checkbox"/>				
Relevant medical history (with focus on relevant prior gynaecological/obstetric history)					