Ribavirin Pregnancy Registry
Instructions for completing the
REGISTRATION FORMS (Obstetric Health Care Provider (Ob HCP)

PREGNANT PATIENT OR OBSTETRIC PROVIDER

General Information: Provide dates in the ddmonyyyy format (e.g. January 1, 2004 is written 01Jan2004).

1. Maternal Information

1.1 **LMP:** Provide the date of the pregnant patient's last menstrual period.

1.2 **Estimated Date of Delivery:** Provide the estimated date of delivery.

1.3 **Corrected Estimated Date of Delivery:** If available, an EDD based on a prenatal test, especially if this is the date being used to calculate gestational age for medication exposures and outcome.

1.4 **Patient Age** (at the time of conception)

1.5 **Race/ Ethnicity:** Check the appropriate box for the pregnant patient's race/ ethnicity. If other, please specify.

2. Clinical Conditions

2.1 **Clinical Conditions:** Check all of the conditions applicable as they were as close to the beginning of the pregnancy as possible.

3. Maternal (Mother of Baby) History

3.1-3.6 Indicate the number of previous pregnancies and, of these, the number of live infants, spontaneous abortions, stillbirths, elective abortions, and defects.

3.7 **Maternal Family History of Birth Defects:** Indicate any family history of birth defects.

4. Paternal (Father of Baby) History

Check if the father of the baby is unknown and skip items 4.1-4.8

4.1-4.7 If the father of baby has fathered children from a previous relationship, indicate the number of previous pregnancies and, of these, the number of live infants, spontaneous abortions, stillbirths, elective abortions, and defects.

4.8 **Paternal Family History of Birth Defects:** Indicate if the father of baby has a family history of birth defects.

Health Care Provider Information: Complete contact information (Obstetric health care provider)

The Registry is not designed to monitor all types of events that might occur during pregnancy, labor and delivery, or other neonatal or postnatal events other than birth defects. If such events occur, the reporter is encouraged to contact the manufacturer of the individual product and/or FDA. FDA can be reached by faxing the information to 800-FDA-0178 or at http://www.fda.gov/medwatch/.

Ribavirin Pregnancy Registry
REGISTRATION FORM (OB HCP)

Fax to: 800-800-1052

Mail to: Ribavirin Pregnancy Registry
1011 Ashes Drive, Wilmington, NC 28405

FOR OFFICE USE ONLY

Registry ID _____

HCP ID _____

Country / State (US) _____

Registry date of notification ____ ____ _____ ☐ Phone

PREGNANT PATIENT OR OBSTETRIC PROVIDER

Log ID: _____ ***(Registry assigned Log ID # – Call the Registry Office for a non-patient identifying number (800-593-2214))***

Patient Name: _____ *(only if authorization received)*

*Note: To help assure patient anonymity the Registry uses a Registry assigned patient ID to refer to your patient to obtain follow-up and outcome information. A **patient log** is provided to you, if this is your first registrant. The Log will help cross-reference this ID with your own identifier(s) for this patient. Keep the log in a secure place.*

1. ☐ MATERNAL INFORMATION

OFFICE USE ONLY: CRA EST. ☐

1.1 Last Menstrual Period: ____ ____ _____ (dd mon yyyy)

1.2 Estimated Date of Delivery: ____ ____ _____ *(by LMP)* (dd mon yyyy)

1.3 Corrected Estimated Date of Delivery: ____ ____ ____ *(e.g., by ultrasound)* (dd mon yyyy)

1.4 Patient Age: _____ *(at conception)*

1.5 Race/ Ethnicity: ☐1 White ☐2 Black ☐3 Hispanic ☐4 Asian ☐5 Other _____ (specify)

2. CLINICAL CONDITION(S) (at the ***START*** of pregnancy) *(√ all that apply)*

2.1 Clinical Conditions *(√all that apply at the **start** of pregnancy):*

☐ A. Hepatitis C (HCV) ☐ B. HIV positive ☐ C. None of the above

3. ☐ MATERNAL (MOTHER OF BABY) HISTORY

3.1 # Previous pregnancies _____

3.2 # Live infants _____

3.3 # Spontaneous abortions (miscarriages) _____

3.4 # Fetal deaths (stillbirths) _____

3.5 # Elective abortions _____

3.6 # Outcomes with defects ____ *(specify defects below)*

_____

3.7 Maternal family history of birth defects – *Describe any family history of birth defects*

_____

_____

_____

_____

_____

4. ☐ PATERNAL (FATHER OF BABY) HISTORY

Check if the "father of the baby" unknown? ☐

4.1 Pregnancies with a previous partner? ☐1 yes *(go to 4.2)* ☐2 no *(if no go to 4.8)*

4.2 # Previous pregnancies _____

4.3 # Live infants _____

4.4 # Spontaneous abortions (miscarriages) _____

4.5 # Fetal deaths (stillbirths) _____

4.6 # Elective abortions _____

4.7 # Outcomes with defects ____ *(specify defects below)*

_____

4.8 Paternal family history of birth defects – *Describe any history of birth defects*

_____

_____

_____

☐ OBSTETRIC HEALTH CARE PROVIDER INFORMATION

Name _____ Specialty _____

Address _____ Phone _____

_____ Fax _____

_____ E-mail _____

Alternate Contact _____ _____

Provider's Signature _____ Date _____ _____ _____ (dd mon yyyy)