Ribavirin Pregnancy Registry
Instructions for completing the
PEDIATRIC FOLLOW-UP – STATUS OF OUTCOME FORM

PEDIATRIC PROVIDER

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

1. Status of Outcome

If there are multiple outcomes (e.g., twins, triplets) provide details for each outcome. Make copies of this page or indicate the information for each outcome.

1.1 **Date of this Assessment**

1.2 ***Date of Birth:** Provide the date of live birth or fetal loss.

1.3 **Gender:** Provide the gender of the infant.

1.4 **Apgar Scores:** Provide Apgar scores. If unknown, please put a dash in the space provided.

1.5 ***Gestational Age:** Provide the gestational age at birth.

1.6 ***Birth Weight:** Provide the weight of the infant at birth. Indicate Provide weight in either lbs/oz OR grams.

1.7 ***Birth Length:** Provide the length of the infant at birth. Provide measurement in either centimeters OR inches.

1.8 **Head Circumference:** Provide the infant's head circumference at birth. Provide measurement in either centimeters OR inches.

OUTCOME INFORMATION: Please complete section 2 ONLY if there is a birth defect noted.

2. Birth Defects

2.1 ***Birth Defect Noted:** Was a structural birth defect noted? Check "yes", "no". If yes, go to Birth Defect Summary Form.

***Critical fields -** Please try to obtain this information. These fields are the most critical for the analysis of risk.

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 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
PEDIATRIC FOLLOW-UP
STATUS OF OUTCOME FORM

Fax to: 800-800-1052
Ribavirin Pregnancy Registry
1011 Ashes Drive, Wilmington, NC 28405

FOR OFFICE USE ONLY

Registry ID _____

HCP ID _____ Baby ID _____

Date Information Received _____ _____ ☐ Phone

Pediatric Follow-up Status ☐ Pending ☐ Complete ☐ LTFU

PEDIATRIC PROVIDER

Patient (Infant) Name: _____

1. ☐ FETAL OUTCOME *(information obtained at first pediatric assessment)*

1.1 Date of this Assessment: _____ _____ _____ (dd mon yyyy)

1.2 *****Date of Birth: _____ _____ _____ (dd mon yyyy)

1.3 Gender: ☐2 Male ☐1 Female

1.4 Apgar Scores: _____ 1 minute
_____ 5 minute

1.5 *****Gestational Age: _____ weeks

1.6 *****Birth Weight: _____ lbs _____ oz OR _____ grams

1.7 *****Birth Length: _____ cm OR _____ in

1.8 Head Circumference: _____ cm OR _____ in

2. ☐ BIRTH DEFECTS *(complete only if birth defects are noted)*

2.1 *****Birth Defect Noted? ☐1 Yes *(if yes, go to Birth Defect Summary Form)* ☐2 No

***Critical Fields**

☐ PEDIATRIC HEALTH CARE PROVIDER INFORMATION

Name _____ Specialty _____

Address _____ Phone _____

_____ Fax _____

_____ Email _____

Alternate Contact _____

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