

## CASE RECORD FORM - SEROEPIDEMIOLOGY OF LASSA VIRUS IN PREGNANCY

### ENROLMENT QUESTIONNAIRE

Study Code	Participant code
LVP-OX	

INCLUSION CRITERIA	Yes	No
Pregnant women attending antenatal clinic (ANC)		
Pregnant women who are willing and able to give informed consent for participation in the study		
Aged $\geq 15$ years		
EXCLUSION CRITERIA	Yes	No
Legally authorised representative (LAR) is absent or unavailable		
Patients for end of life care		
Participant withdraws consent		

If the eligibility criteria have been confirmed, the individual can be enrolled in the study

# ENROLMENT QUESTIONNAIRE

## ENROLMENT VISIT DATES

Date of inclusion or enrolment	___/___/___
Date of interview	___/___/___
Name of site/clinic hospital	<input type="checkbox"/> Irrua Specialist Teaching Hospital (ISTH) <input type="checkbox"/> Esan West <input type="checkbox"/> Esan Central
Full Name of staff completing the questionnaire	
Signature of staff completing the questionnaire	

## ENROLMENT MEDICAL DATA

### Demographic Data

<b>1. Date of birth (DD/MM/YYYY)</b>  <i>If the patient doesn't know her date of birth then record this as 15/06/YYYY. The year of birth can be extrapolated from the age.</i>	___/___/___
<b>2. Age</b>	[__   __ ] years
<b>3. Date of last normal menstrual period</b>	___/___/___ <input type="checkbox"/> Certain <input type="checkbox"/> Uncertain <input type="checkbox"/> Unknown
<b>4. Current gestational age based on LNMP</b>	[__   __ ] Weeks
<b>5. Gestational age from fundal height</b>	[__   __ ] Weeks
<b>6. Estimated date of delivery</b>	___/___/___
<b>7. Residence</b>	<input type="checkbox"/> Urban <input type="checkbox"/> Rural
<b>8. Area of residence in last 6 months (district name)</b>	
<b>9. Religion</b>	<input type="checkbox"/> None <input type="checkbox"/> Christian <input type="checkbox"/> Muslim <input type="checkbox"/> Traditional religions <input type="checkbox"/> if Other religion specify:
<b>10. Educational level</b>	<input type="checkbox"/> No formal education <input type="checkbox"/> Formal education- primary <input type="checkbox"/> Formal education – secondary

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	<input type="checkbox"/> Formal education – tertiary
<b>11. Occupation</b>	<input type="checkbox"/> None (no profession) <input type="checkbox"/> Housewife <input type="checkbox"/> Healthcare Occupations ( <i>nurse, ward assistants, doctors etc</i> ) <input type="checkbox"/> Farming and Forestry Occupations <input type="checkbox"/> Education ( <i>student/teacher at any level</i> ) <input type="checkbox"/> Office and Administrative Occupations ( <i>banking, legal, management, public office etc</i> ) <input type="checkbox"/> Other specify
<b>12. Knowledge of Lassa Fever risk factors</b>	<input type="checkbox"/> No knowledge <input type="checkbox"/> 1 or 2 risk factors <input type="checkbox"/> 3 or more risk factors (good)
<b>13. Knowledge of Lassa Fever transmission</b>	<input type="checkbox"/> No knowledge <input type="checkbox"/> 1 or 2 routes <input type="checkbox"/> 3 or more routes (good)
<b>In the last 6 months has she</b>	
<b>14. Been exposed to rodents</b>  <i>(e.g. eating, or rats seen at home, rat burrows in house or killing rats at home)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>15. Cared for someone who was bleeding due to unknown causes</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>16. Participated in funeral rites (washing of the body/clothes of deceased)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>17. Cared for someone who was diagnosed with Lassa fever</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>18. Cared for someone who died of unknown causes</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Medical and Obstetric History (*verify with ANC and/or hospital notes*)

<b>19. Number of previous pregnancies (excluding present pregnancy):</b>	[ _   _ ]
<b>20. Number of previous births after 22 weeks' gestation:</b>	[ _   _ ]
<b>21. Number of livebirths</b>	[ _   _ ]

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22. Have any previous babies been premature (<37weeks of gestation)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
23. Have any previous babies weighed less than 2.5kg?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
24. Has she been treated for Lassa fever in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
25. Has she been diagnosed with Lassa fever during this pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
26. Has she had any fevers in the last 2 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
27. Has she been diagnosed with any of the following chronic medical conditions <b>before</b> pregnancy? (tick all that apply)	<input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Other If other medical complications specify?
28. Has she been diagnosed with gestational diabetes in this pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
29. Has she been diagnosed with pregnancy –induced hypertension (PIH) in this pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
30. Has she been diagnosed with pre-eclampsia in this pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
31. Has she been diagnosed with eclampsia in this pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
32. Are there any other pregnancy-related complications	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes specify other pregnancy related complications:
33. Has she been diagnosed with HIV?	<input type="checkbox"/> Yes

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	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not answered
<b>34.</b> Has she had Malaria during the current pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>35.</b> Has she been vaccinated for tetanus?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>36.</b> If yes to question 26 above, number of tetanus (TT) vaccines received?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
<b>37.</b> Please list all medication she is currently using?  <hr style="width: 20px; margin-left: 0;"/> <i>(use generic names NOT brand names)</i>	
<b>38.</b> On what date was the 1 <sup>st</sup> (enrolment) blood sample collected from mother? <i>(DD/MM/YYYY e.g. 01/02/2019)</i>	___/___/_____
<b>39.</b> At what time was the 1 <sup>st</sup> (enrolment) blood sample was collected from mother? <i>(time in 24hour e.g 13:05 or 08:05)</i>	[ _   _ : _   _ ]

**Ultrasound Results (do not use old ultrasound results unless they are ≤ 1 week old)**

<b>40.</b> Was ultrasound performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>41.</b> If no why was it not performed	<input type="checkbox"/> Patient refused <input type="checkbox"/> Patient not cooperative <input type="checkbox"/> Ultrasound machine not functional <input type="checkbox"/> Other If other reason specify:
<b>42.</b> Ultrasound date	

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	_ / _ / _
<b>43.</b> Gestational age by ultrasound	[ _   _ ] Weeks
<b>44.</b> Fetal growth restriction	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>45.</b> Any other significant findings on Ultrasound	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes specify:

**Has a BLOOD SAMPLE been collected for this patient?**

**Cross-check that all questions have been answered.**

**Give the patient a yellow card, explain she should call the number on the card when in labour.**