



Cerclage Suture Type for an Insufficient Cervix and its effect on Health outcomes (C-STICH)

CRF5 Part B: C-STICH Maternal Outcome.

PLEASE COMPLETE THIS FORM AT 7 DAYS POST NATAL.

PLEASE FOLLOW THE INSTRUCTIONS IN RED FOR COMPLETING THIS FORM.

Section 1. Patient Details:

Patient's trial number:

Patient's Date of Birth (MMM-YYYY): -

Section 2. Information About the Mother:

1. Did the mother develop a fever (38°C or above?) whilst an inpatient postnatally?

YES (≥ 38°C)	NO (≤ 37.9°C)	If 'Yes', please record highest temperature °C
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

2. Did the mother receive any antibiotics whilst an inpatient postnatally?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
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If yes, please answer the remainder of Q2, otherwise proceed to Q3.

2a. What was the indication for antibiotics (Please tick all that apply)?:

	YES	NO
• Prophylaxis following MROP/ Perineal tear.	<input type="checkbox"/>	<input type="checkbox"/>
• Endometritis.	<input type="checkbox"/>	<input type="checkbox"/>
• Urinary Tract Infection.	<input type="checkbox"/>	<input type="checkbox"/>
• Other.	<input type="checkbox"/>	<input type="checkbox"/>

If other, please specify:

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Section 2. Information about the mother continued:

2b. Which antibiotic(s) did the mother receive (please tick yes or no to the following)?

β-lactam antibiotics:

	YES	NO
Intravenous benzyl penicillin		
Intravenous co-amoxiclav		
Intravenous cephalosporin		
Oral cephalosporin		
Oral co-amoxiclav		

Other antibiotics

	YES	NO
Intravenous gentamicin		
Intravenous clindamycin		
Intravenous metronidazole		
Oral nitrofurantoin		
Oral metronidazole		
Other (<i>Please specify below</i>)		

If other antibiotic (please specify here):

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Section 2. Information about the mother continued:

*Defined as infection plus any 2 systemic manifestations of infection from the following: Fever $\geq 38^{\circ}\text{C}$ or hypothermia $<36^{\circ}\text{C}$, tachycardia (HR >90), tachypnoea (respiratory rate >20).

YES NO

3. Did the mother develop any sepsis within the pregnancy or within 7 days postnatal*?

If the mother developed sepsis, please answer the remainder of Q3. If No, go to Q4.

3a. When was the onset of sepsis? (please tick one box only):

During Pregnancy? <input type="checkbox"/> If during pregnancy, what was the gestation of sepsis? Weeks <input type="checkbox"/> Days <input type="checkbox"/>	Postnatal? <input type="checkbox"/> If postnatal, please specify the number of days postnatal from delivery? Days <input type="checkbox"/>
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3b. What was the primary site of infection? (Please tick one box only)

YES

- Urinary Tract
- Chorioamnionitis
- Endometritis
- Wound infection
- Other

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

If Other, please specify.....

YES NO

3c. Was the infection confirmed on culture?

3d. If Yes, which organism was identified on culture? (Please tick Yes or No to all)

- E.coli
- Group B streptococci
- Group A streptococci
- Other

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

If Other, please specify

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Section 2. Information about the mother (continued):

3e. Which antibiotic(s) was the mother given to treat the sepsis (Please tick Yes or No to all)?

β-lactam antibiotics:

	YES	NO
Intravenous benzyl penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Intravenous cephalosporin	<input type="checkbox"/>	<input type="checkbox"/>
Intravenous co-amoxiclav	<input type="checkbox"/>	<input type="checkbox"/>
Oral cephalosporin	<input type="checkbox"/>	<input type="checkbox"/>
Oral co-amoxiclav	<input type="checkbox"/>	<input type="checkbox"/>

Other antibiotics

	YES	NO
Intravenous gentamicin	<input type="checkbox"/>	<input type="checkbox"/>
Intravenous clindamycin	<input type="checkbox"/>	<input type="checkbox"/>
Intravenous metronidazole	<input type="checkbox"/>	<input type="checkbox"/>
Other (<i>Please specify below</i>)	<input type="checkbox"/>	<input type="checkbox"/>

If other antibiotic (please specify here):

	YES	NO
4. Did the mother spend any time post delivery in the HDU?	<input type="checkbox"/>	<input type="checkbox"/>

If YES, How many days?

	YES	NO
5h. Did the mother spend any time post delivery in the ITU?	<input type="checkbox"/>	<input type="checkbox"/>

If YES, How many days?

IF THE MOTHER HAS SUFFERED A SERIOUS ADVERSE EVENT PLEASE COMPLETE CRF7 SERIOUS ADVERSE EVENT REPORTING FORM AND FAX IT TO THE C-STICH TRIALS OFFICE

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Section 3. Some information about you:

Your Name:

Your Centre:

Today's date:

D	D
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M	M	M
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Y	Y	Y	Y
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THANK YOU FOR COMPLETING THIS FORM

Please enter the information from this CRF into the C-STICH online database
by logging in at trials.bham.ac.uk/CSTICH

OR return a copy of the completed form to the trials office to be entered on-
to the database. Please return to:

C-STICH Trial, FREEPOST RTGS-UKLK-JKHS, Birmingham Clinical Trials Unit,
Institute of Applied Health Research, University of Birmingham, B15 2TT

Or by fax to **0121 415 9136**

Or via email to cstich@trials.bham.ac.uk