

# UK ITP REGISTRY PREGNANCY REGISTRATION SHEET (2.0)



**Participant Name:**

**Date of Data Collection:**

**Registry Identification Code (RIC):**

Participant Details			
<b>Date of Birth:</b>		<b>Date consented for Pregnancy Registry:</b>	
<b>Estimated Delivery Date:</b>		<b>Diagnosis Date (if during pregnancy):</b>	
<b>Ethnicity:</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <b>White</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> English/Welsh/Scottish/Northern Irish/British</li> <li><input type="checkbox"/> Irish</li> <li><input type="checkbox"/> Gypsy or Irish Traveller</li> <li><input type="checkbox"/> Any other White background</li> </ul> <b>Mixed/Multiple ethnic groups</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> White and Black Caribbean</li> <li><input type="checkbox"/> White and Black African</li> <li><input type="checkbox"/> White and Asian</li> <li><input type="checkbox"/> Any other Mixed/Multiple ethnic background</li> </ul> </div> <div style="width: 48%;"> <b>Asian/Asian British</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Indian</li> <li><input type="checkbox"/> Pakistani</li> <li><input type="checkbox"/> Bangladeshi</li> <li><input type="checkbox"/> Chinese</li> <li><input type="checkbox"/> Any other Asian background</li> </ul> <b>Black/ African/Caribbean/Black British</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> African</li> <li><input type="checkbox"/> Caribbean</li> <li><input type="checkbox"/> Any other Black/African/Caribbean background</li> </ul> <b>Other ethnic group</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Arab</li> <li><input type="checkbox"/> Any other ethnic group</li> </ul> </div> </div>			
Clinician Information			
	<b>Haematologist's Details</b>	<b>Obstetrician's Details</b>	<b>Maternity Unit</b>
Name			
Hospital			
Town/ City			
Obstetric History			
<b>Is this the first pregnancy registered on the UK ITP Registry?</b> <div style="text-align: center; margin-top: 10px;"> <input type="checkbox"/> Yes  <input type="checkbox"/> No         </div>			
<b>No. of previous pregnancies beyond 24 weeks gestation?</b>		<b>No. of previous pregnancies less than 24 weeks gestation?</b>	

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Problems in previous pregnancies-did the participant experience any of the below in previous pregnancies?	Date of Event
3 or more miscarriages up to 12 weeks gestation Mid trimester loss 12-24 weeks gestation Late pregnancy loss after 24 weeks gestation Baby with Congenital anomaly Eclampsia Gestational diabetes Infant requiring admission to the neonatal unit Infection requiring hospital admission Massive Haemorrhage Neonatal death Placenta Praevia Placental abruption Post-partum haemorrhage requiring transfusion Preeclampsia Preterm birth (between 24-37 weeks gestation) Still birth Surgical procedure in pregnancy Other (please specify)	
Morbid events in previous pregnancy- did the participant experience any of the below in previous pregnancies?	Date of Event
Adult Respiratory Distress Syndrome Cardiac Arrest Disseminated Intravascular Coagulation Haemolysis, elevated liver function, low platelets (HELLP) Required mechanical ventilator support Septicaemia Other (please specify)	