BEXSERO® PREGNANCY REGISTRY

PATIENT REGISTRATION FORM

Return by FAX to: 866-898-0564
Registry Phone Number: 877-413-4759

FOR OFFICE USE ONLY

Registry ID _____ State _____

Registry date of notification _____ _____ _____
DD MMM YYYY

☐ Phone

1. MINIMUM CRITERIA FOR REGISTRY ENROLLMENT

1.1 ☐ Administration of BEXSERO vaccination within 30 days prior to the last menstrual period (LMP) or at any time during the pregnancy

1.2 ☐ Patient is currently pregnant

- OR -

☐ Patient is not currently pregnant; a birth defect was noted at pregnancy outcome

- OR -

☐ De-identified report from HCP network / HMO

1.3 ☐ Consent provided

- OR -

☐ Consent not applicable - de-identified report from HCP network / HMO

1.4 ☐ Patient agrees to provide Personal and Health Care Provider contact information and consent for release of medical information

- OR -

☐ Consent not applicable - de-identified report from HCP network / HMO

2. MATERNAL INFORMATION

2.1 Last Menstrual Period (LMP): ____ _____ _____
DD MMM YYYY
☐ Unknown

2.2 Estimated Date of Delivery (EDD): ____ _____ _____
DD MMM YYYY
☐ Unknown

2.3 Corrected Estimated Date of Delivery (CEDD): ____ _____ _____
DD MMM YYYY
(e.g., by ultrasound)
☐ Unknown

2.4 Patient's Age at Conception: _____
☐ Unknown

2.5 Ethnicity: Hispanic or Latino? ☐ Yes ☐ No

2.6 Race (check all that apply):
☐ White/Caucasian
☐ Black/African American
☐ American Indian/Alaska Native
☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ Other (Specify _____)
☐ Unknown

3. MATERNAL OBSTETRICAL HISTORY

Number of previous pregnancies: ***(excluding current pregnancy)*** _____

Number of previous full term live births: _____

Number of previous preterm live births: _____

Number of previous spontaneous abortions: _____

Number of previous induced abortions: _____

Number of previous ectopic pregnancies: _____

Number of previous molar pregnancies: _____

Number of previous stillbirths: _____

3.1 Provide number of previous pregnancy outcomes with birth defects: _____

Please specify birth defect(s) for each pregnancy outcome affected:

_____

_____

Please list contributing factors for each birth defect:

_____

_____

4. RELEVANT FAMILY HISTORY OF BIRTH DEFECTS: ☐ None ☐ Unknown

Birth Defect(s)	**Relationship to Participant**
1. _____	_____
2. _____	_____
3. _____	_____

Provider's Signature (if applicable)_____ Date ____ _____ _____

Provider's Printed Name _____ DD MMM YYYY

Provider's Specialty _____

Name of Reporter Completing Form If Other Than Provider _____ Function Title:_____

☐ This check indicates that all blank fields represent data that is not available