BORN ONTARIO COVID-19 CASE REPORT FORM

See BORN Q & A document for additional details about data collection.

- BORN Ontario is urgently requesting data collection from Ontario hospitals and midwifery practice groups for any cases of COVID-19 during pregnancy between March 1, 2020 until the end of the pandemic.

- The aim is to collect case information at individual hospitals and midwifery practice groups; this information will then be securely transferred to BORN Ontario and linked with the BORN Information System (BIS) to get information about pregnancy outcomes. Do **not** send case reports form through email (use BIS messaging or BORN secure FTP server). Detailed instructions on how to securely transfer case reports to BORN can be found on questions 19 and 20 in the 'Frequently Asked Questions' document on the BORN website.

Update re Data Collection (May 1, 2020):

BORN has received questions about submitting suspected or probable cases. Because a small number of infected individuals test negative (either due to undetectable viral load, poorly executed swabs, or false negatives), please use your best clinical judgement on deciding whether to include suspected or probable cases, even if the test is negative.

We suggest including probable/suspected cases (even if the test is negative) when there are:

- highly suspicious clinical signs/symptoms (fever AND at least one other symptom of respiratory disease, e.g., cough, shortness of breath, X-ray findings)
- other symptoms but the woman has been in close contact with an infected individual

Data should be collected for two types of cases:

1) Any pregnant individual with **CURRENT** COVID-19 (confirmed, suspected or probable) ***regardless of gestational age***

   This includes:

   a) pregnant individuals admitted to hospital for current COVID-19-related issues (e.g., pneumonia)
   b) pregnant individuals admitted to hospital for birth or, any other pregnancy-related issues (e.g., preeclampsia, bleeding etc.), who happen to currently have COVID-19
   c) pregnant individuals cared for outside the hospital (e.g., home or birth centre) by midwives

2) Any pregnant individual with a **PAST HISTORY** of COVID-19 during pregnancy (confirmed, suspected or probable), which is resolved

   This includes:

   a) pregnant individuals at the time of hospital birth or out-of-hospital birth, who have a history of COVID-19 during this pregnancy from which they have recovered

There are two data collection options (both within this data collection form):

OPTION A: CORE DATASET: variables required for record linkage to the BORN Information System (BIS) + core variables about COVID-19

- ***These core variables are shaded in light red***
- ***These core variables are the priority***
- ***Please complete ALL core variables (shaded)***

OPTION B: EXPANDED DATASET: core dataset variables + additional clinical variables about COVID-19

- ******This dataset is preferred, if possible***
- ***Please complete ALL core variables (shaded), as well as all other applicable variables as completely as possible***

SUBMITTING ORGANIZATION:	**DATE CASE FORM COMPLETED:**

Variable Name	Data Format	Comments
Type of case (SELECT ONE)	☐ Pregnant individual with **CURRENT** COVID-19 (confirmed, suspected or probable) ☐ Pregnant individual with a **PAST HISTORY** of COVID-19 during pregnancy (confirmed, suspected or probable)	- *World Health Organization (WHO) definitions for confirmed, suspected or probable are provided below and in the BORN Q & A document

***World Health Organization (WHO) definitions for confirmed, suspected or probable COVID-19:**

Confirmed COVID-19:

i. person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms

Suspected COVID-19:

i. person with **acute respiratory illness** (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath) **AND** a history of travel to or residence in a location reporting community transmission of COVID-19 disease during the 14 days prior to symptom onset; **OR**
ii. person with **acute respiratory illness AND** having been in contact with a confirmed or probable COVID-19 case in the last 14 days prior to symptom onset; **OR**
iii. person with **severe acute respiratory illness** (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath; **AND** requiring hospitalization) **AND** in the absence of an alternative diagnosis that fully explains the clinical presentation

Probable COVID-19:

i. suspected case for whom testing for the COVID-19 virus is inconclusive; OR
ii. suspected case for whom testing could not be performed for any reason

COVID-19 Immunization Status		
Has this person ever received a COVID-19 vaccine?		
If yes, was the COVID-19 vaccine given during this pregnancy?		Leave blank if not applicable
If yes, which vaccine?		Leave blank if not applicable
If yes, date(s) of immunization with COVID-19 vaccine:	MM/DD/YYYY MM/DD/YYYY MM/DD/YYYY	Leave blank if not applicable

Identifiers required for record linkage with BORN Information System (BIS)		
Mother's last/family name(s)		
Mother's first/given name(s)		
Mother's date of birth (DOB)	MM/DD/YYYY	
Mother's province of residence		- Use 'Other' for non-residents (e.g., a visitor to Canada)
Mother's health card number (e.g., OHIP; RAMQ; Public Service Health Care Plan)		- Use upper case for any letters - No spaces and no dashes between any letters or digits (e.g.,1111111111AA)
Mother's residence postal code		- No space between first three and last three characters (e.g., M5S1W7)
Mother's hospital chart number		- For out of hospital births add Midwifery Client Code
Estimated date of birth (EDB)	MM/DD/YYYY	- Leave blank if unknown - Best estimate of date of birth determined by ultrasound or mathematical calculation using Nägele's rule. Same as EDC and EDD.

Maternal SARS-CoV-2 exposure history		
Travel history to affected country		
Known contact in community		
Health care worker		
Other (e.g., occupational exposure)		- Leave blank if not applicable
Unknown	☐	- Check box if unknown

Maternal SARS-CoV-2 testing (performed in pregnancy or at birth)		
CORE VARIABLES		
Was at least one SARS-CoV-2 lab test performed?		
- **IF YES**, did at least one lab test have a positive result?		
- **IF YES**, sample collection date of FIRST positive SARS-CoV-2 lab test	MM/DD/YYYY	- Date of sample collection - Leave blank if no positive test / no test performed / result pending
ADDITIONAL CLINICAL VARIABLES		
Nasopharyngeal (NP) swab 1		- RT-PCR test 1, please indicate if different test is performed
- Sample collection date	MM/DD/YYYY	- Leave blank if no test
- Lab report date	MM/DD/YYYY	- Leave blank if no test
- Result		- Leave blank if no test

Nasopharyngeal (NP) swab 2		- RT-PCR test 2, please indicate if different test is performed
- Sample collection date	MM/DD/YYYY	- Leave blank if no second test
- Lab report date	MM/DD/YYYY	- Leave blank if no second test
- Result		- Leave blank if no second test
Nasopharyngeal (NP) swab 3		- RT-PCR test 3, please indicate if different test is performed
- Sample collection date	MM/DD/YYYY	- Leave blank if no third test
- Lab report date	MM/DD/YYYY	- Leave blank if no third test
- Result		- Leave blank if no third test
Throat swab		
- Sample collection date	MM/DD/YYYY	- Leave blank if no test
- Lab report date	MM/DD/YYYY	- Leave blank if no test
- Result		- Leave blank if no test
Blood		
- Sample collection date	MM/DD/YYYY	- Leave blank if no test
- Lab report date	MM/DD/YYYY	- Leave blank if no test
- Result		- Leave blank if no test
Breastmilk		
- Sample collection date	MM/DD/YYYY	- Leave blank if no test
- Lab report date	MM/DD/YYYY	- Leave blank if no test
- Result		- Leave blank if no test
Amniotic fluid		
- Sample collection date	MM/DD/YYYY	- Leave blank if no test
- Lab report date	MM/DD/YYYY	- Leave blank if no test
- Result		- Leave blank if no test

Serology - IgM		
- Sample collection date	MM/DD/YYYY	- Leave blank if no test
- Lab report date	MM/DD/YYYY	- Leave blank if no test
- Result		- Leave blank if no test
Serology - IgG		
- Sample collection date	MM/DD/YYYY	- Leave blank if no test
- Lab report date	MM/DD/YYYY	- Leave blank if no test
- Result		- Leave blank if no test
Name of other SARS-CoV-2 testing		- Leave blank if no test
- Sample collection date	MM/DD/YYYY	- Leave blank if no test
- Lab report date	MM/DD/YYYY	- Leave blank if no test
- Result		- Leave blank if no test

Were any of the following other samples tested for SARS-CoV-2 at birth?		
Placenta		
- **IF YES**, what was the test result?		- Leave blank if no test
Cord blood		
- **IF YES**, what was the test result?		- Leave blank if no test
High vaginal swab		
- **IF YES**, what was the test result?		- Leave blank if no test

Other viral tests (performed in pregnancy or at birth)		
Were any of the following viral tests performed?	☐ Yes, Influenza ☐ Yes, Respiratory-Syncytial Virus (RSV) ☐ No other viral testing performed ☐ Unknown	- SELECT ALL THAT APPLY
- **IF YES**, swab date viral testing performed	MM/DD/YYYY	- Leave blank if no test
- **IF YES**, result of viral testing	☐ Positive for Influenza A ☐ Positive for Influenza B ☐ Positive for Respiratory Syncytial Virus (RSV) ☐ Negative for Influenza A, B and RSV ☐ Results pending ☐ Unknown/Indeterminate	- SELECT ALL THAT APPLY - Leave blank if no test

Maternal COVID-19 clinical symptoms observed or reported in pregnancy or at birth		
CORE VARIABLES		
Fever		
Cough		
Shortness of breath		
ADDITIONAL CLINICAL VARIABLES		
Date of COVID-19 diagnosis, if known	MM/DD/YYYY	- Leave blank if unknown
Estimated date of infection, if known	MM/DD/YYYY	- Leave blank if unknown
Fever (> 38°C)		
- **IF YES**, date of onset	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
- **IF YES**, max temp recorded	°C	- Leave blank if not applicable
Cough		
- **IF YES**, date of onset	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable

Headache		
- **IF YES**, date of onset	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
Shortness of breath		
- **IF YES**, date of onset	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
Muscle pain/myalgia		
- **IF YES**, date of onset	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
Anorexia (loss of appetite)		
- **IF YES**, date of onset	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
Diarrhea		
- **IF YES**, date of onset	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
Vomiting		
- **IF YES**, date of onset	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
Malaise		
- **IF YES**, date of onset	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
Anosmia (loss of smell)		
- **IF YES**, date of onset	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable

Other symptoms:		- Leave blank if not applicable
- **IF YES**, date of onset	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable

Maternal chest imaging related to COVID-19 illness		
CORE VARIABLES		
Was chest imaging related to COVID-19 performed?		
- **IF YES**, what was chest imaging result?		
ADDITIONAL CLINICAL VARIABLES		
X-ray test performed?		
- **IF YES**, x-ray result		- Leave blank if not applicable
CT scan test performed?		
- **IF YES**, CT scan result		- Leave blank if not applicable
MRI test performed?		
- **IF YES**, MRI result		- Leave blank if not applicable
Other imaging (non-chest), specify		
- **If YES, test result**		- Leave blank if not applicable

Maternal SARS-CoV-2 complications (in pregnancy or at birth)		
CORE VARIABLES		
Hospitalized for COVID-19 illness?		
- **IF YES**, date of hospital admission	MM/DD/YYYY	
- **IF YES**, date of hospital discharge	MM/DD/YYYY	- Date of discharge from *your* hospital
- **IF YES**, was person admitted to ICU during this admission?		

- **IF YES**, transferred to another hospital for care?		- Choose option from dropdown
Was there a maternal death related to COVID-19 illness?		
- **IF YES**, date of death	MM/DD/YYYY	- Leave blank if not applicable
ADDITIONAL CLINICAL VARIABLES		
Pneumonia?		
- **IF YES**, date	MM/DD/YYYY	- Leave blank if not applicable
Sepsis?		
- **IF YES**, date	MM/DD/YYYY	- Leave blank if not applicable
Respiratory failure?		
- **IF YES**, date	MM/DD/YYYY	- Leave blank if not applicable
Acute respiratory distress syndrome?		
- **IF YES**, date	MM/DD/YYYY	- Leave blank if not applicable
Heart failure?		
- **IF YES**, date	MM/DD/YYYY	- Leave blank if not applicable
Septic shock?		
- **IF YES**, date	MM/DD/YYYY	- Leave blank if not applicable
Coagulopathy?		
- **IF YES**, date	MM/DD/YYYY	- Leave blank if not applicable
Disseminated intravascular coagulopathy?		
- **IF YES**, date	MM/DD/YYYY	- Leave blank if not applicable
Renal failure?		
- **IF YES**, date	MM/DD/YYYY	- Leave blank if not applicable
Liver dysfunction?		-
- **If YES,** date	MM/DD/YYYY	-

Other, specify?		-
- **IF YES,** date		-

Maternal treatment for COVID-19 illness in pregnancy or at birth		
CORE VARIABLES		
Did person receive ventilatory support during a hospital admission for COVID-19 illness?		If more than one type of support was used during the admission, indicate the most invasive option
ADDITIONAL CLINICAL VARIABLES		
Start date of ECMO (if received)	MM/DD/YYYY	- Leave blank if not applicable
Duration of ECMO (if received)	days	- Leave blank if not applicable
Start date of invasive mechanical ventilation (if received)	MM/DD/YYYY	- Leave blank if not applicable
Duration of invasive mechanical ventilation (if received)	days	- Leave blank if not applicable
Start date of non-invasive mechanical ventilation (if received)	MM/DD/YYYY	- Leave blank if not applicable
Duration of non-invasive mechanical ventilation (if received)	days	- Leave blank if not applicable
Intravenous immunoglobulin		
- **IF YES**, dose		- Leave blank if not applicable
- **IF YES**, date started	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
High-flow nasal cannula oxygen therapy		
- **IF YES**, date started	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable

Any other oxygen (outside of labour and delivery)		
- **If YES**, date started	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
- Maximal L per minute		- Leave blank if not applicable
Renal replacement therapy		
- **IF YES**, date started	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES**, duration	days	- Leave blank if not applicable
Other, specify		-
- **IF YES,** date started	MM/DD/YYYY	- Leave blank if not applicable
- **IF YES,** duration	days	- Leave blank if not applicable

Maternal COVID-19 medications and natural health products in pregnancy or at birth		
Over-the-counter medications: acetaminophen (Tylenol)		
Over-the-counter medications: acetylsalicylic acid (Aspirin)		
Over-the-counter medications: ibuprofen (Advil, Motrin, others)		
Over-the-counter medications: Naproxen (Aleve, Naprosyn, others)		
Over-the-counter medications: Other		
- **IF YES**, specify all		- Specify all additional over-the-counter medications; separated by semi-colon - Leave blank if not applicable

Prescription medications: Corticosteroids		
- **IF YES**, specify all		- Specify all corticosteroids; separated by semi-colon - Leave blank if not applicable
Prescription medications: Vasopressors		-
- **IF YES,** specify all		- Specify all vasopressors; separated by semi-colon - Leave blank if not applicable
Prescription medications: Steroids for fetal lung maturation		
- **IF YES**, specify all		- Specify all steroids for fetal lung maturation; separated by semi-colon - Leave blank if not applicable
Prescription medications: Chloroquine		
- **IF YES**, describe circumstance		- Describe circumstances for chloroquine prescription - Leave blank if not applicable
Prescription medications: Hydrochloroquine		
- **IF YES**, describe circumstance		- Describe circumstances for hydrochloroquine prescription - Leave blank if not applicable

Prescription medications: Colchicine		
Prescription medications: Kaletra (Lopinavir/Ritonavir)		
Prescription medications: Remdesivir		
Prescription medications: Antibiotics		
- **IF YES**, specify all		- Specify all antibiotics; separated by semi-colon - Leave blank if not applicable
Prescription medications: Other		
- **IF YES**, specify all		- Specify all additional prescription medications; separated by semi-colon - Leave blank if not applicable
Natural health products		
- **IF YES**, specify all		- Specify all natural health products; separated by semi-colon - Leave blank if not applicable

Delivery (other variables about pregnancy, birth and newborn will be obtained via record linkage with the BORN Information System)		
Number of fetuses		- Please contact BORN Ontario for triplets or higher-order multiples (this form will accommodate data from singletons and twins only)
Outcome of pregnancy during this clinical encounter	☐ Pregnancy loss <20 weeks and <500 grams (spontaneous miscarriage or termination of pregnancy) ☐ Stillbirth at ≥20 weeks or ≥500 grams (spontaneous or termination of pregnancy) ☐ Live birth ☐ Pregnancy continued (undelivered)	- Outcome of pregnancy during this admission, including live births, stillbirths, terminations, losses and pregnancy terminations - Pregnancy continued refers to a person who is undelivered at end of this clinical encounter - **IF TWINS**, SELECT ALL THAT APPLY (e.g., if there is 1 live birth and 1 stillbirth, select each applicable box)
- **IF A BIRTH OCCURRED**, where did it occur?	Baby B, if twins: (*Dropdown box appears underneath*)	- Choose option from dropdown - If twins, choose option for Baby A and Baby B - Leave blank if pregnancy continued (undelivered) at the end of this clinical encounter
- **IF A BIRTH OCCURRED,** what was the mode of delivery?	(*Dropdown box appears underneath*)	- Choose option from dropdown - Leave blank if pregnancy continued (undelivered) at the end of this clinical encounter
- **IF A BIRTH OCCURRED**, what was the date of birth?	MM/DD/YYYY (singletons or Baby A of twins) MM/DD/YYYY (Baby B, if twins)	- Provide date for live births, stillbirths, terminations, losses - Leave blank if pregnancy continued (undelivered) at the end of this clinical encounter
- **IF A BIRTH OCCURRED**, what was the gestational age?	weeks + days (singletons or Baby A of twins) weeks + days (Baby B, if twins)	- Provide for live births, stillbirths, terminations, losses - Leave blank if pregnancy continued (undelivered) at the end of this clinical encounter
- **IF LIVE BIRTH OR STILLBIRTH OCCURRED**, what was the birth weight?	grams (singletons or Baby A of twins) grams (Baby B, if twins)	- Provide for live births and stillbirths only - Leave blank if pregnancy continued (undelivered) at the end of this clinical encounter

Newborn(s) from birth to discharge (if a birth occurred during this clinical encounter)		
Management of newborn(s)	☐ 1: Newborn asymptomatic and kept with well mother in hospital room or home ☐ 2: Newborn asymptomatic and isolated away from mother in another area in hospital (postnatal ward, special care nursery, NICU or special ward) or home ☐ 3: Newborn symptomatic and isolated away from mother in another area in hospital (postnatal ward, neonatal nursery, NICU or special ward) or home ☐ 4: Newborn transferred to another setting/hospital due to clinical needs (e.g., baby admitted to NICU/SCN or another unit) ☐ 5: Other Baby B, if twins: (*provide applicable number from response options above*)	- **SELECT ALL THAT APPLY** If twins, select one tick box for Baby A and provide applicable number from response options on line below for Baby B - Leave blank if pregnancy continued (undelivered) at the end of this clinical encounter - For option #4, this can include newborns transferred to another unit or hospital where there may or may not be restrictions on mother visits/contact
Was there an NICU admission?	Baby B, if twins:	- Choose option from dropdown - If twins, choose option for Baby A and Baby B - Leave blank if pregnancy continued (undelivered) at the end of this clinical encounter

Newborn feeding (if a birth occurred during this clinical encounter)

- **SELECT ALL THAT APPLY**
- Provide response in this table for singletons or Baby A of twins (separate table for Baby B is below)
- Leave blank if pregnancy continued (undelivered) at the end of this clinical encounter

Type of feeding in first 48 hours	Fed by mother	Fed by alternate health care provider or family, who is NOT currently COVID-19 positive and is NOT a contact of a current COVID-19 case	Fed by alternate health care provider or family, who is either currently COVID-19 positive or a contact of a current COVID-19 case	Fed by unknown person (i.e., we know what the baby received, but we don't know who fed the baby)
Breast fed	☐	N/A	N/A	N/A
Expressed breast milk	☐	☐	☐	☐
Breast milk substitute – formula	☐	☐	☐	☐
Donor milk	☐	☐	☐	☐
☐ Intravenous and/or TPN				

*Note: alternate health care provider or family member who is asymptomatic is presumed to be COVID-19 negative

Newborn feeding (if a birth occurred during this clinical encounter) – BABY B, IF TWINS

- **SELECT ALL THAT APPLY**
- **IF TWINS**, provide Baby B response in this table (leave blank if it was a singleton birth)
- Leave blank if pregnancy continued (undelivered) at the end of this clinical encounter

Type of feeding in first 48 hours	Fed by mother	Fed by alternate health care provider or family, who is NOT currently COVID-19 positive and is NOT a contact of a current COVID-19 case	Fed by alternate health care provider or family, who is either currently COVID-19 positive or a contact of a current COVID-19 case	Fed by unknown person (i.e., we know what the baby received, but we don't know who fed the baby)
Breast fed	☐	N/A	N/A	N/A
Expressed breast milk	☐	☐	☐	☐
Breast milk substitute – formula	☐	☐	☐	☐
Donor milk	☐	☐	☐	☐
☐ Intravenous and/or TPN				

Newborn(s) SARS-CoV-2 testing (if a birth occurred during this clinical encounter)		
CORE VARIABLES		
Was at least one SARS-CoV-2 lab test performed on the infant(s)?	Baby B, if twins:	- Choose option from dropdown - If twins, choose option for Baby A and Baby B - Leave blank if pregnancy continued (undelivered) at the end of this clinical encounter
- **IF YES**, did at least one lab test have a positive result?	Baby B, if twins:	- Leave blank if no test - If twins, choose option for Baby A and Baby B - Leave blank if pregnancy continued (undelivered) at the end of this clinical encounter
ADDITIONAL CLINICAL VARIABLES		
Nasopharyngeal (NP) swab 1		- RT-PCR test 1
- Sample collection date	MM/DD/YYYY Baby B, if twins: MM/DD/YYYY	- Leave blank if no test
- Lab report date	MM/DD/YYYY Baby B, if twins: MM/DD/YYYY	- Leave blank if no test
- Result	Baby B, if twins:	- Leave blank if no test - If twins, choose option for Baby A and Baby.
Nasopharyngeal (NP) swab 2		- RT-PCR test 2
- Sample collection date	MM/DD/YYYY Baby B, if twins: MM/DD/YYYY	- Leave blank if no second test
- Lab report date	MM/DD/YYYY Baby B, if twins: MM/DD/YYYY	- Leave blank if no second test
- Result	Baby B, if twins:	- Leave blank if no second test - If twins, choose option for Baby A and Baby B.

Nasopharyngeal (NP) swab 3		- RT-PCR test 3
- Sample collection date	MM/DD/YYYY Baby B, if twins: MM/DD/YYYY	- Leave blank if no third test
- Lab report date	MM/DD/YYYY Baby B, if twins: MM/DD/YYYY	- Leave blank if no third test
- Result	Baby B, if twins:	- Leave blank if no third test - If twins, choose option for Baby A and Baby B.
Throat swab		
- Sample collection date	MM/DD/YYYY Baby B, if twins: MM/DD/YYYY	- Leave blank if no test
- Lab report date	MM/DD/YYYY Baby B, if twins: MM/DD/YYYY	- Leave blank if no test
- Result	Baby B, if twins:	- Leave blank if no test - If twins, choose option for Baby A and Baby B.
Serology - IgM		
- Sample collection date	MM/DD/YYYY Baby B, if twins: MM/DD/YYYY	- Leave blank if no test
- Lab report date	MM/DD/YYYY Baby B, if twins: MM/DD/YYYY	- Leave blank if no test
- Result	Baby B, if twins:	- Leave blank if no test - If twins, choose option for Baby A and Baby B.

Serology - IgG		
- Sample collection date	MM/DD/YYYY Baby B, if twins: MM/DD/YYYY	- Leave blank if no test
- Lab report date	MM/DD/YYYY Baby B, if twins: MM/DD/YYYY	- Leave blank if no test
- Result	Baby B, if twins	- Leave blank if no test - If twins, choose option for Baby A and Baby B.

ADDITIONAL COMMENTS	
	- Leave blank if no comments