Severe Chronic Neutropenia International Registry	**Patient ID Number**: ___/___ ___/___ ___/___ ___ ___ ___ ___ **Patient Initials**: ___ ___ ___

PREGNANCY # _____ OUTCOME *(Complete page for each pregnancy)*

☐ Miscarriage/termination, date ___/____/___ Gestational Age: _____ weeks
Please specify: ☐ elective termination or ☐ spontaneous
Check reason and describe on back of form: ☐ mother's medical condition
☐ abnormal fetal development
☐ other_____

☐ Still birth, date ___/____/___ Gestational Age: _____ weeks

Specify reason, if known: _____

☐ Live birth, date ___/____/___ Initials: _____ ☐ Male ☐ Female

Weight: _____ Gestational Age: _____ weeks

CBC (newborn) checked? ☐ No ☐ Yes
☐ Normal
☐ Neutropenia ☐ Transient
☐ Chronic

Complications (newborn)? ☐ No ☐ Yes, describe on back of form.
☐ Congenital abnormalities
☐ Other medical diagnoses

Complications (maternal)? ☐ No ☐ Yes, describe on back of form.

Mother nursed infant? ☐ No ☐ Yes If yes, cytokine administered to mother? ☐ No ☐ Yes

Cytokine (growth factor, e.g., G-CSF) administered during pregnancy? ☐ No ☐ Yes

If yes, indicate (1) cytokine brand name: _____
(2) trimester and cytokine dose (circle dose units and indicate frequency.):

First trimester, _____ [cc] or [ml] or [mcg] or [mcg/kg] _____ frequency

Second trimester, _____ [cc] or [ml] or [mcg] or [mcg/kg] _____ frequency

Third trimester, _____ [cc] or [ml] or [mcg] or [mcg/kg] _____ frequency

Mother's weight before pregnancy: _____ ☐ lb ☐ kg

Did patient stop cytokine treatment? ☐ No ☐ Yes, stop date: _____

If yes, specify reason: _____

Please use the back of this form to provide any additional information about patient or infant.