



Biomnis

**Clinical Information Form**  
**Investigation for foetal/neonatal thrombocytopenia**

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**IDENTITY OF THE PARENTS**

**MOTHER** First name(s): .....  
 Maiden name: .....  
 Accepted name: .....  
 ABO blood group: .....

**Gynaecological history**

Gravida: ..... Parity: .....  
 Miscarriage(s) during the second trimester:  
 NO  YES (please specify the number): .....

**FATHER** First name(s): .....  
 Surname: .....  
 ABO blood group: .....

**CLINICIAN**

Clinician's name: .....  
 Department: .....  
 Address: .....  
 Post code: [ ][ ][ ][ ][ ][ ] City: .....  
 Country: .....  
 E-Mail: .....  
 Telephone: .....

**PROGRESS OF THE PREGNANCY**

**Foetal abnormality on ultrasound:**  NO  YES: ..... Stage: ..... weeks  
**Treatment during pregnancy:**  NO  YES: .....  
**Disease(s) during pregnancy** (gestational thrombocytopenia, IUGR, alteration of the foetal heart rate, etc.):  
 .....

**IF THE BIRTH HAS TAKEN PLACE**

**Mode of delivery:**  Vaginal  Caesarean section  
**Baby's surname at birth:** ..... **Forename of the baby** .....  
**Date of birth:** [ ][ ][ ][ ][ ][ ][ ][ ] **Gestational age:** ..... weeks **Weight of the neonate:** .....g  
**Infection:**  NO  YES (please specify): .....  
**Respiratory distress:**  NO  YES  
**Signs of haemorrhage:**  Petechiae/ecchymosis  Intracranial haemorrhage

Platelet count of the infant:	..... 10 <sup>9</sup> /L	..... 10 <sup>9</sup> /L	..... 10 <sup>9</sup> /L	..... 10 <sup>9</sup> /L	..... 10 <sup>9</sup> /L	..... 10 <sup>9</sup> /L
Date:	.....	.....	.....	.....	.....	.....
Days after birth:	Delivery (D0)					
	<input type="checkbox"/> Cord blood	D .....	D .....	D .....	D .....	D .....
	<input type="checkbox"/> Blood from infant					

**IF THE NEONATE HAS RECEIVED TREATMENT**

**Platelet transfusion:**  Pooled platelets  
 Volume of transfusion: ..... mL Platelet content: ..... 10<sup>11</sup>  
 Apheresis platelets:  non-phenotyped  phenotyped HPA- .....  
 Volume of transfusion: ..... mL Platelet content: ..... 10<sup>11</sup>  
 Apheresis platelets of maternal origin  
 Volume of transfusion: ..... mL Platelet content: ..... 10<sup>11</sup>  
 **Other blood product transfusion:**  Packed RBC  FFP  
 **IgIV** Posology: ..... Dose: ..... Product:  CLAIRYG  GAMMAGARD  KIOVIG  OCTAGAM  
 PRIVIGEN  SANDOGLOBULIN  TEGELINE  
 **Other treatment** (antibiotic treatment, etc.): .....