Please return this form to Lipomed AG, Fabrikmattenweg 4, CH-4144 Arlesheim, Switzerland by mail (save@lipomed.com) or fax (Fax No. +41 61 702 02 20)

MATERNAL DATA

Initials: ☐☐☐

Birth date (day month year): ☐☐☐☐☐☐

Body surface area: ☐ . ☐☐ m^2

Weight: ☐☐☐ . ☐ kg

Height: ☐☐☐ cm

Week of gestation: ☐☐

Estimated date of delivery (day month year): ☐☐☐☐☐☐

Previous pregnancies and their outcome

☐ no

☐ yes

if yes, number ☐☐, outcome ....

....

Medical History (list pre-existing medical conditions and other relevant history)

....

....

....

....

Risk factors:

☐ Nicotine ☐ Alcohol ☐ Drug abuse ☐ Other ....

☐ Additional information ....

....

Family history (e. g. risk factors, underlying diseases) ....

....

....

Medication prior to (if relevant) and during pregnancy

Trade name/ Drug name	Lot. No.	Expiry date	Route of adminis-tration	Daily dose	Therapy dates from	to	Indication(s) for use

Complications / Adverse events occurred during pregnancy?

☐ no ☐ yes

if yes, please fill in the separate Adverse Event Report Form which will be send to you

RELEVANT TESTS / LABORATORY DATA (e. g. prenatal diagnostics, serology tests, other)

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....

PRESENT COURSE OF PREGNANCY

☐ without complications

☐ planned induced abortion

other...

PATERNAL DATA; IF APPROPRIATE

Initials: ☐☐☐ Birth date: (day month year) ☐☐☐☐☐☐

Body surface area: ☐ . ☐☐ m^2 Weight: ☐☐☐ . ☐ kg Height: ☐☐☐ cm

Medical History (list pre-existing medical conditions and other relevant history)

....

....

....

....

Risk factors:

☐ Nicotine ☐ Alcohol ☐ Drug abuse ☐ Other...

☐ Additional information ....

....

Family history (e. g. risk factors, underlying diseases) ....

....

....

Medication prior to conception (if relevant)

Trade name/ Drug name	Lot. No.	Expiry date	Route of adminis-tration	Daily dose	Therapy dates from	to	Indication(s) for use

QUALIFIED REPORTING PERSON

Name: ....

Address: ....

Postal code: .... City: ....

State: .... Country: ....

Telephone: .... Profession: ....

OK to report your name to local Health Authority? ☐ yes ☐ no

Was report submitted to local Health Authority? ☐ yes ☐ no

If yes, please specify authority: ....

Signature: .... Date: day month year

SUBMISSION OF A REPORT DOES NOT NECESSARILY CONSTITUTE A JUDGEMENT THAT THE DRUG CAUSED THE ADVERSE EVENT.

Will be completed by Lipomed AG or local monitor only:

Company data:	**Report source:**	**Status:**	**Reported to health authorities:**
National organization: Contact person: Signature: Date: day month year	☐ Market ☐ Health Professional ☐ Consumer ☐ Other: ☐ Health Authority ☐ Literature ☐ Study Study number: Patient number:	☐ Initial ☐ Follow-up Date report was received by company: Date: day month year	☐ Yes ☐ No