CRF PAPER

PREVALENCE OF PSYCHIATRIC DISORDERS DURING PREGNANCY: A FEASIBILITY STUDY AT SECOND TRIMESTER ULTRASOUND IN THE GENERAL POPULATION (GROUP STUDY) - STUDY PROTOCOL

Principal investigator : Pr Raoul Belzeaux

PROMOTOR : CHU DE MONTPELLIER2023-XX-XXXX

Visit 1 :

Inclusion centre :

Signature of consent :

First name initial :

Name initial :

Pseudo-anonymisation code :

Age :

Postcode :

E-mail address :

Inclusion criteria :

- ☐ Woman
- ☐ Major
- ☐ Pregnant and consulting for a scheduled second-trimester ultrasound scan
- ☐ Able to read and write with a good knowledge of French

Non-inclusion criteria :

- ☐ Inability to understand French
- ☐ No access to reading and writing
- ☐ Patient under 18 at the time of the second trimester ultrasound scan
- ☐ Patient under guardianship or curatorship
- ☐ Patient deprived of her liberty

Concerning blood sampling in a PAXgene tube (2.5 mL) :

- ☐ Yes
  - ➔ Filing date :
- ☐ No
  - ➔ Reason for refusal :
    - ☐ Insufficient venous capital
    - ☐ Phobia
    - ☐ Other : Please specify: _____

Visit 2:

1. Socio-demographic data :

What is the name of your general practitioner?

What is your marital status?

- ☐ Married / in a couple
- ☐ Single / separated / divorced
- ☐ Do not wish to reply

Where do you live?

- ☐ Personal residence
- ☐ Parental home
- ☐ Residential home
- ☐ Homeless
- ☐ Other (please specify) :

Do you consider your home to be stable?

- ☐ Yes
- ☐ No
- ☐ Do not wish to reply

What level of education have you achieved?

- ☐ Primary school
- ☐ Brevet des collèges
- ☐ Baccalauréat
- ☐ Bac +1
- ☐ Bac +2
- ☐ ≥ Bac +3
- ☐ Do not wish to reply

What is your current professional situation?

- ☐ Student or trainee
- ☐ Salaried activity
- ☐ Unemployed
- ☐ At home
- ☐ Self-employed
- ☐ Retired
- ☐ Other professional activity, please specify :

  _____
- ☐ Do not wish to reply

What social security cover do you have?

- ☐ Social security
- ☐ AME
- ☐ PUMa (ex-CMU)
- ☐ C2S (formerly CMUc)

☐ Do not wish to reply

3. Medical history excluding obstetrics and psychiatry

☐☐**No health problems to report**Yes No

If no :

	Year of diagnosis	Stable (yes/no)	Treatments *(Trade name + daily dosage)*
Cardiovascular diseases, cardiovascular risk factors and metabolic diseases : ☐☐Y es No			
Infarction, stroke		☐ Yes ☐ No	
Pericarditis, myocarditis, tamponade		☐ Yes ☐ No	
Angina, angina pectoris		☐ Yes ☐ No	
Rhythm disorder		☐ Yes ☐ No	
Pulmonary embolism		☐ Yes ☐ No	
Arteritis, arterial stenosis		☐ Yes ☐ No	
Hypertension		☐ Yes ☐ No	
Type 2 diabetes		☐ Yes ☐ No	
Type 1 diabetes		☐ Yes ☐ No	
Hypercholesterolemia		☐ Yes ☐ No	
Hypertriglyceridemia		☐ Yes ☐ No	
Gout, hyperuricemia (uric acid)		☐ Yes ☐ No	
Haemochromatosis		☐ Yes ☐ No	
Other			
Endocrine diseases			
Pituitary adenoma, prolactin excess		☐ Yes ☐ No	
Hypothyroidism		☐ Yes ☐ No	
Thyroid nodule(s)		☐ Yes ☐ No	

Hyperthyroidism		☐ Yes ☐ No	
Thyroidectomy (partial or total removal of the thyroid gland)		☐ Yes ☐ No	
Goitre		☐ Yes ☐ No	
Parathyroid diseases		☐ Yes ☐ No	
Adrenal diseases		☐ Yes ☐ No	
Other			
Circulatory problems ☐☐Y es No			
Venous insufficiency, circulatory problems		☐ Yes ☐ No	
Varicose veins		☐ Yes ☐ No	
Phlebitis		☐ Yes ☐ No	
Raynaud's disease		☐ Yes ☐ No	
Other			
Respiratory diseases ☐☐Y es No			
Chronic bronchitis, obstructive pulmonary disease (COPD), emphysema		☐ Yes ☐ No	
Respiratory failure		☐ Yes ☐ No	
Asthma		☐ Yes ☐ No	
Bronchial dilatation		☐ Yes ☐ No	
Sleep apnea		☐ Yes ☐ No	
Pneumothorax		☐ Yes ☐ No	
Other			
Digestive diseases or problems ☐☐Y es No			
Polyps, diverticula (intestine, colon, rectum)		☐ Yes ☐ No	
Peptic ulcer disease, gastritis		☐ Yes ☐ No	
Gastro-oesophageal reflux disease, achalasia, hiatal hernia		☐ Yes ☐ No	

Irritable bowel syndrome, functional colopathy, constipation		☐ Yes ☐ No	
Haemorrhagic rectocolitis (UC)		☐ Yes ☐ No	
Celiac disease (gluten intolerance)		☐ Yes ☐ No	
Crohn's disease		☐ Yes ☐ No	
Haemorrhoids		☐ Yes ☐ No	
Hepatitis		☐ Yes ☐ No	
Cirrhosis of the liver, chronic liver disease		☐ Yes ☐ No	
Biliary lithiasis (stones in the gallbladder), cholecystectomy		☐ Yes ☐ No	
Gastro, Gastroenteritis		☐ Yes ☐ No	
Other			
Diseases or problems affecting bones and joints ☐☐Y es No			
Osteoarthritis, rheumatism		☐ Yes ☐ No	
Back pain, neck pain, backache, lower back pain, lumbago...		☐ Yes ☐ No	
Herniated discs, sciatica, cruralgia		☐ Yes ☐ No	
Rheumatoid arthritis		☐ Yes ☐ No	
Ankylosing spondylitis, psoriatic arthritis		☐ Yes ☐ No	
Periarthritis, epicondylitis, capsulitis, tendonitis, carpal tunnel...		☐ Yes ☐ No	
Fibromyalgia, chronic fatigue syndrome		☐ Yes ☐ No	
Osteoporosis, osteopenia		☐ Yes ☐ No	
Wrist fracture		☐ Yes ☐ No	
Hip fracture (neck of femur)		☐ Yes ☐ No	
Fracture of a vertebra		☐ Yes ☐ No	
Sprains, dislocations and other fractures		☐ Yes ☐ No	
Other			

Neurological diseases or problems ☐☐Y es No			
Migraines		☐ Yes ☐ No	
Headaches		☐ Yes ☐ No	
Neuralgia		☐ Yes ☐ No	
Multiple sclerosis		☐ Yes ☐ No	
Epilepsy		☐ Yes ☐ No	
Alzheimer's disease		☐ Yes ☐ No	
Parkinson's disease		☐ Yes ☐ No	
Memory problems		☐ Yes ☐ No	
Other			
Allergies ☐☐Y es No			
Food allergy		☐ Yes ☐ No	
Allergy to medicines		☐ Yes ☐ No	
Respiratory allergies (rhinitis, sinusitis, bronchitis, etc.)		☐ Yes ☐ No	
Skin or mucous membrane allergy (conjunctivitis)		☐ Yes ☐ No	
Other			
Genitourinary diseases ☐☐Y es No			
Renal insufficiency		☐ Yes ☐ No	
Urinary incontinence, bladder weakness		☐ Yes ☐ No	
Renal lithiasis, kidney stones, renal colic		☐ Yes ☐ No	
Adenoma of the prostate, benign prostatic hypertrophy		☐ Yes ☐ No	
Endometriosis, adenomyosis		☐ Yes ☐ No	
Uterine fibroid with or without surgery		☐ Yes ☐ No	
Ovarian cysts, ovarian dystrophy		☐ Yes ☐ No	

Ovulation disorders, amenorrhoea		☐ Yes ☐ No	
Infertility		☐ Yes ☐ No	
Other			
Skin diseases ☐☐Y es No			
Acne and related inflammatory diseases		☐ Yes ☐ No	
Eczema		☐ Yes ☐ No	
Urticaria		☐ Yes ☐ No	
Psoriasis		☐ Yes ☐ No	
Other			
Eye diseases ☐☐Y es No			
Macular degeneration, AMD		☐ Yes ☐ No	
Glaucoma and/or ocular hypertension		☐ Yes ☐ No	
Cataract		☐ Yes ☐ No	
Retinal detachment, vitreous detachment		☐ Yes ☐ No	
Other			
ENT diseases ☐☐Y es No			
Tinnitus		☐ Yes ☐ No	
Vertigo, Meniere's disease		☐ Yes ☐ No	
Deafness, hearing problems		☐ Yes ☐ No	
Other			
Haematological and systemic diseases ☐☐Y es No			
Anemia, Biermer's disease		☐ Yes ☐ No	
Lupus erythematosus		☐ Yes ☐ No	
Sarcoidosis (BBS), Behçet's disease, Gougerot Sjören's syndrome, scleroderma		☐ Yes ☐ No	

Other			
Infectious diseases ☐☐Y es No			
Acute respiratory infection, bronchitis, pneumonia		☐ Yes ☐ No	
ENT infections, strep throat, sinusitis, nasopharyngitis, otitis		☐ Yes ☐ No	
Acute urinary and/or renal infection, cystitis, pyelonephritis		☐ Yes ☐ No	
Genital infection, salpingitis, prostate infection, bartholinitis...		☐ Yes ☐ No	
Influenza, flu-like illness		☐ Yes ☐ No	
Tuberculosis, primary tuberculosis infection		☐ Yes ☐ No	
Infectious mononucleosis		☐ Yes ☐ No	
Mycosis, candidiasis, lichen		☐ Yes ☐ No	
Zona		☐ Yes ☐ No	
Malaria		☐ Yes ☐ No	
AIDS, HIV		☐ Yes ☐ No	
Papillomavirus		☐ Yes ☐ No	
Herpes (cutaneous, genital)		☐ Yes ☐ No	
Other			
Cancer (please specify)		☐ Yes ☐ No	

4. Obstetric medical history (excluding current pregnancy)

How many pregnancies have you had (full term or not)?_____

How many children do you have? _____

What was your last contraceptive method?

- ☐ No contraception
- ☐ The oestroprogestogenic pill
- ☐ Progestin-only pill
- ☐ Ring
- ☐ Implant
- ☐ Hormonal coil
- ☐ Copper coil
- ☐ Mechanical contraception
- ☐ Other contraception (please specify) : _____

Did you suffer from a gynaecological pathology during one of your pregnancies?

☐Yes ☐ No ☐Do not wish to answer

If yes :

	Year of diagnosis	If treatment *(Trade name + daily dosage)*
Ectopic pregnancy		
Spontaneous miscarriage		
Voluntary termination of pregnancy		
Medical termination of pregnancy		
Pregnancy-induced hypertension / Pre-eclampsia		
Gestational diabetes		
Maternal-foetal infection		
Growth retardation in utero		
Placenta praevia / retroplacental haematoma		
Threat of premature delivery		
Delivery haemorrhage		

Caesarean section		
Other (please specify) :		

5. Personal psychiatric medical history

	Asked by a doctor	Suspected by the patient	Starting year	Stable (Yes / No)	Treatment
Neurodevelopmental disorders					
Autism spectrum disorder					
Attention deficit disorder +/- hyperactivity					
Other (please specify) :					
Psychotic disorders					
Schizophrenia					
Schizoaffective disorder					
Other (please specify) :					
Mood disorders					
Type 1 bipolar disorder					
Type 2 bipolar disorder					
Bipolar disorder (type unknown)					
Characteristic depressive episode					
Persistent depressive disorder					
Other (please specify) :					
Anxiety disorders					
Specific phobia					
Social phobia					

Generalized anxiety disorder					
Agoraphobia					
Other (please specify) :					
Eating disorders					
Anorexia nervosa					
Bulimia					
Bulimic hyperphagia					
Other (please specify) :					
Personality disorders					
Borderline personality					
Other (please specify) :					
Other psychiatric disorders					
Obsessive-compulsive disorder					
Premenstrual dysphoric syndrome					
Post-traumatic stress disorder					
Dissociative identity disorder					
Other (please specify) :					

Due to a psychiatric disorder, in the last 12 months, have you :

- ☐ Consulted a health professional
- ☐ Hospitalized
- ☐ Went to emergency
- ☐ Summer in a support group
- ☐ Had a prescription for medication
- ☐ None of the above

Are you under the care of a psychiatrist?

☐ Yes ☐ No

If so, was this monitoring continued during the pregnancy?

☐ Yes ☐ No

Have you had contact with a professional specialising in perinatal psychiatry/psychology?

☐ Yes ☐ No

Concerning psychotropic treatment

Did you take any psychotropic medication in the 12 months prior to pregnancy? ☐ ☐ Yes No

If yes: Specify molecule and

☐ Anxiolytic :
☐ Hypnotic :
☐ Anti-depressant :
☐ Thymoregulator :
☐ Antipsychotic :
☐ Other : Please specify: _____

For each drug mentioned by the patient, ask the following questions

Who prescribed these treatments?

☐ General practitioner
☐ Psychiatrist
☐ Other (please specify) :

Was the planned pregnancy or the pregnancy the reason for a change in treatment? ☐ ☐ Yes No

If yes, specify for each therapeutic class the drug, the dosage, the initiator and the reason for the change.

	Before		Date	After		Initiator	Design
Therapeutic class	**Molecule**	**Dosage**		**Molecule**	**Dosage**		
Anxiolytic						☐ Doctor ☐ Patient ☐ Family	
Hypnotic						☐ Doctor ☐ Patient ☐ Family	
Anti-depressant						☐ Doctor ☐ Patient ☐ Family	
Thymoregulator						☐ Doctor ☐ Patient ☐ Family	
Antipsychotic						☐ Doctor ☐ Patient ☐ Family	
Other						☐ Doctor ☐ Patient ☐ Family	

6. Consumption of toxic substances

	Asked by a doctor	Suspected by the patient	Starting year	Stable (Yes / No)	Treatment
Substance use disorder					
Alcohol use disorder					
Other (please specify) :					

How would you describe your alcohol consumption

- ☐ Never
- ☐ Occasional
- ☐ Several times a week
  - ➔ how many glasses of alcohol do you drink a day?
- ☐ Every day

How many glasses of alcohol do you drink a day? How would you describe your smoking habits

- ☐ Assets
  - ➔ Number of packs and how many

- ☐ Weaned
- ☐ Never

Do you use any other substances?

- ☐ Cannabis
- ☐ Cocaine
- ☐ Heroin
- ☐ Sedatives / anxiolytics / hypnotics
- ☐ Opiates
- ☐ Hallucinogens
- ☐ Stimulants
- ☐ CBD
- ☐ Other (please specify) :
- ☐ No substance use

In relation to a substance use disorder, in the last 12 months, have you :

- ☐ Consulted a health professional
- ☐ Hospitalizede
- ☐ Summer in an outpatient clinic, a detox programme
- ☐ Been to emergency or a crisis centre
- ☐ Received treatment
- ☐ None of the above

7. Family psychiatric medical history

Father :

☐☐B iological father Adoptive father ☐☐ Dont know ☐Do not wish to answer

Status of biological or adoptive father :

☐ Living ☐ Deceased other than by suicide ☐ Died by suicide ☐ Do not wish to answer

Father's psychiatric history :

- ☐ Depression
- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Anxiety disorder
- ☐ Alcohol use disorder
- ☐ Substance use disorder (please specify) :
- ☐ Other (please specify)
- ☐ Don't know

☐ none

Mother :

☐☐B iological mother Adoptive mother ☐Don't know ☐Do not wish to answer

Status :

☐☐ ☐A live Died not by suicide Died by suicide ☐ Do not wish to answer

Psychiatric history

☐ Depression
- ○ ☐During pregnancy: Yes ☐No ☐Do not wish to answer

☐ Bipolar disorder
☐ Schizophrenia
☐ Anxiety disorder
- ○ ☐During pregnancy: Yes ☐No ☐Do not wish to answer

☐ Alcohol use disorder
☐ Substance use disorder (please specify) :
☐ Other (please specify)
☐ Don't know

Siblings

Number of siblings : ____

Patient's sibling number :	1	2	3	4	5
Sex					
Year of birth					
Status					
Living					
Died non-suicide					
Died by suicide					
Psychiatric disorders					
Depression					
If female, during pregnancy (yes/no)					

Bipolar disorder					
Schizophrenia					
Anxiety disorder					
If female, during pregnancy (yes/no)					
Alcohol use disorder					
Substance use disorder (please specify)					
Other (please specify)					
Don't know					

8. Concerning current pregnancy

Date of start of pregnancy : ___ / ___ / _____

☐ ☐ Multiple pregnancyYes No

If yes, specify the number of children : ____

Desired/planned pregnancy (use the appropriate term according to the parent's situation) :
☐ ☐ Yes No

☐ ☐ Pregnancy at risk: Yes No

☐ ☐ Health problems during pregnancy: Yes No

If yes :

	Tick if yes	
Pregnancy-induced hypertension / Pre-eclampsia	☐	
Gestational diabetes	☐	
Maternal-foetal infection	☐	
In utero growth retardation	☐	
Threat of premature delivery	☐	
Other (please specify) :	☐	

Current weight (kg): _____ - Height (m): _____ - BMI: _____ *(automatic calculation)*

Did you attend a gynaecological emergency during your pregnancy?

- ☐ Yes
- ☐ No

During the 1st trimester, were you bothered by vomiting?

- ☐ Yes
- ☐ No

If yes, did you have to...?

- ☐ Talk to your midwife / doctor
- ☐ Go to emergency
- ☐ Be hospitalised
- ☐ Dedicated medication
- ☐ Adopt other strategies (please specify) :
- ☐ No treatment

Care pathway

Who was the first person you contacted about your pregnancy?

- ☐ Medical gynaecologist
- ☐ Gynaecologist-obstetrician
- ☐ Midwife
- ☐ General practitioner
- ☐ Other (please specify)
- ☐ No treatment

When was this first contact made?

Do you have a referring doctor for the current treatment?

☐ Yes (please specify) : ☐ No

Which professionals are following your pregnancy?

- ☐ Medical gynaecologist
- ☐ Gynaecologist-obstetrician
- ☐ Midwife
- ☐ General practitioner
- ☐ Other (please specify)
- ☐ No follow-up

Do you have a regular doctor or a doctor registered as such with social security?

☐ Yes (please specify name) : ☐ No

Have you visited your GP or midwife to prepare for the pregnancy (preconception consultation)?

☐ Yes ☐ No

Have you had an early prenatal interview (1st trimester of pregnancy)?

☐ Yes ☐ No

If yes, with whom?

- ☐ Medical gynaecologist
- ☐ Gynaecologist-obstetrician
- ☐ Midwife
- ☐ General practitioner
- ☐ Other (please specify)

9. +Time taken to complete the simplified EPICES questionnaire + Paykel MINI + CSSR-S inventory

For the attending doctor (in V2) :

Name of doctor : _____

Attending physician wishes to participate in the study: yes no

Are you the patient's GP? ☐ ☐ Yes No

Do you know of any psychiatric history concerning the patient? ☐ ☐ Yes No

If yes, is it recorded in the patient's medical records? ☐ ☐ Yes No

If yes :

- ☐ Depression
- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Anxiety disorder
- ☐ Alcohol use disorder
- ☐ Substance use disorder (please specify) :
- ☐ Other (please specify)
- ☐ Don't know
- ☐ none

If yes, are you managing the patient's psychiatric pathology? ☐ ☐ Yes No

If yes, is she being treated by a psychiatrist? ☐ ☐ Yes No

☐☐Current treatments**Yes** **No**

☐☐☐☐*If **yes*** - Number of current medications**1 2 3 4 and more**

	Commercial name of drug	Daily dosage in mg *(If unknown, enter 98)*
1		
2		
3		
4		

If 4 or more - If the patient is taking more than 6 of the above treatments, give the same information as for the above medications.

As the patient is pregnant, were you able to have a pre-conception consultation? ☐ ☐ Yes No

Did you detect any fragility/vulnerability in this patient? ☐ ☐ Yes No

Did you put her in touch with carers specialising in perinatal psychiatry/psychology? ☐ ☐ Yes No

Did she come to you during her pregnancy to monitor her pregnancy? ☐ ☐ Yes No

Maternity file collection form (for V2)

Investigator's initials :

Does the medical record mention an early prenatal interview?

☐ Yes ☐ No

If yes, by whom was it carried out?

- ☐ Medical gynaecologist
- ☐ Gynaecologist-obstetrician
- ☐ Midwife
- ☐ General practitioner
- ☐ Other (please specify) : _____

Are any psychiatric diagnoses mentioned?

☐ Yes ☐ No

If yes, is/are this/these a specific DSM5 diagnosis(es)?

- ☐ Yes
- ☐ No

If yes :

- ☐ Depression
- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Anxiety disorder
- ☐ Alcohol use disorder
- ☐ Substance use disorder (please specify) :
- ☐ Other (please specify)
- ☐ Don't know
- ☐ none

Visit 3 :

1. Concerning childbirth and the post-natal period

When did you give birth (even if the foetus died in utero)

How did you go into labour

- ☐ Spontaneous
- ☐ Triggered
- ☐ No labour (caesarean section)

What was the mode of delivery?

- ☐ Spontaneous vaginal delivery without instruments
- ☐ Spontaneous vaginal delivery with instruments (forceps / spatulas / suction cups)
- ☐ Planned caesarean section
- ☐ Emergency caesarean section

Was there an accompanying person?

- ☐ Yes
- ☐ No

If yes, specify the accompanying person : ☐☐☐☐Spouse Family member Friend Other : Please specify: _____

Did you receive epidural analgesia?

☐ Yes ☐ No

If not, why not?

- ☐ Personal choice
- ☐ No longer possible (delivery too advanced)
- ☐ Medical contraindication
- ☐ Other (please specify) :

Were there any complications during the birth?

☐ Yes ☐ No

If yes, which ones?

- ☐ Post-partum haemorrhage without transfusion
- ☐ Post-partum haemorrhage with transfusion
- ☐ Other not requiring transfer or stay in intensive care (please specify) :
- ☐ Other requiring transfer or stay in intensive care (please specify) :

Current weight (kg): _____ - Automatic BMI calculation: _____

2. Pregnancy and childbirth (from ENP 2021)

How would you describe your pregnancy?

- ☐ 1: a pleasant time
- ☐ 2: a fairly pleasant time, despite some difficult moments
- ☐ 3 : a difficult time
- ☐ 4: a very difficult time

If answers 2 to 4, what were your main difficulties?

- ☐ Feeling lonely
- ☐ Long days
- ☐ Lack of advice or support from professionals
- ☐ Feeling very tired
- ☐ Stress about the baby or the birth
- ☐ Nausea, vomiting, back pain
- ☐ Other (please specify) :

Are you satisfied with the medical care and monitoring of your pregnancy?

- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied

During your pregnancy or birth, did healthcare professionals ever say things that made you feel uncomfortable, shocked or hurt?

- ☐ Never
- ☐ Very rarely
- ☐ Sometimes
- ☐ Often

During your pregnancy or childbirth, did healthcare professionals sometimes make gestures that made you feel uncomfortable, shocked or hurt?

- ☐ Never
- ☐ Very rarely
- ☐ Sometimes
- ☐ Often

During your pregnancy or childbirth, did any healthcare professionals ever behave in a way that made you feel uncomfortable, shocked or hurt?

- ☐ Never
- ☐ Very rarely
- ☐ Sometimes
- ☐ Often

If you answered **Sometimes or Often** to any of the last 3 questions, when did this happen?

- ☐ During pregnancy monitoring consultations
- ☐ During ultrasounds
- ☐ During emergency consultations

- ☐ During the anaesthetic
- ☐ During the birth
- ☐ During your stay in the maternity unit
- ☐ Other (please specify) :

During your pregnancy, did the midwife or doctor ask for your consent before performing vaginal examinations (examining the cervix to see if it is open or closed)?

- ☐ Never
- ☐ Yes, sometimes
- ☐ Yes, systematically
- ☐ No vaginal touching
- ☐ Don't know

During labour in the delivery room, did you receive an infusion of artificial oxytocin (a product to increase the intensity or frequency of contractions, marketed under the name Syntocinon®)?

- ☐ Yes
- ☐ No
- ☐ I do not know

If yes, did the midwife or doctor ask for your agreement to start the product?

- ☐ Yes
- ☐ No
- ☐ Don't know

Have you had an episiotomy (scissors cut in the perineum)?

- ☐ Yes
- ☐ No
- ☐ I don't know

If yes, did the midwife or doctor ask for your consent?

- ☐ Yes
- ☐ No
- ☐ Don't know

Have you had an unscheduled or emergency caesarean section?

- ☐ Yes
- ☐ No
- ☐ I don't know

If yes, did the medical team ask for your agreement to carry it out?

- ☐ Yes
- ☐ No
- ☐ Don't know

Are you satisfied with the way you were looked after by the professionals in the delivery room?

- ☐ Very satisfied
- ☐ Somewhat satisfied

- ☐ Rather dissatisfied
- ☐ Very dissatisfied

How did you feel accompanied by the health professionals in the delivery room or operating theatre?

- ☐ They were there for me throughout my labour
- ☐ They were there for me during medical examinations or when I asked them for help
- ☐ They were not very present
- ☐ They were not available

The following questions concern what happened with the healthcare professionals you met during your stay in the maternity unit (delivery and post-natal care) (e.g. doctors, midwives, nurses, physiotherapists, dieticians or any other professionals working in the healthcare field).

How easy or difficult was it for you to do each of the following five things?

Have good discussions about your health with midwives or doctors :

- ☐ Impossible or always difficult
- ☐ Generally difficult
- ☐ Sometimes difficult
- ☐ Generally easy
- ☐ Always easy

Talk to healthcare professionals until you understand everything you need to understand:

- ☐ Impossible or always difficult
- ☐ Generally difficult
- ☐ Sometimes difficult
- ☐ Generally easy
- ☐ Always easy

Ask questions of healthcare professionals to obtain the information you need:

- ☐ Impossible or always difficult
- ☐ Generally difficult
- ☐ Sometimes difficult
- ☐ Generally easy
- ☐ Always easy

Make sure that healthcare professionals understand your situation:

- ☐ Impossible or always difficult
- ☐ Generally difficult
- ☐ Sometimes difficult
- ☐ Generally easy
- ☐ Always easy

Feel able to discuss your health problems with a health professional:

- ☐ Impossible or always difficult
- ☐ Generally difficult
- ☐ Sometimes difficult
- ☐ Generally easy

☐ Always easy

How do you remember your delivery?

☐ Very good
☐ Rather good
☐ Rather bad
☐ Very bad

Would you recommend a relative (sister, friend, etc.) to give birth in the same maternity hospital as yours?

☐ Yes
☐ No
☐ No opinion

2. Concerning the newborn

MFIU? yes no

Death of the child in the first few months of life? yes no

How long after the birth were you able to spend one consecutive hour with your child (number of hours)? ____

In what week of amenorrhoea was your child born?

Was he or she born prematurely (before 37 weeks of amenorrhoea)? ☐ ☐ Yes No

What was his birth weight (in g)? : _____

☐ ☐ APGAR score known : Yes No

If yes, specify the APGAR score at 1 minute of life : _____

If yes, specify APGAR score at 5 minutes of life: _____

☐ ☐ Placenta weight known: Yes No

If yes, specify the weight of the placenta :

Did the condition of the placenta at birth require hospitalisation? ☐ ☐ Yes No

If yes, was the baby admitted to intensive care? ☐ ☐ Yes No

How long did your stay in the maternity hospital last (number of days)? ____

Was your stay extended? ☐ ☐ Yes No

If yes, why was your stay extended?

☐ Maternal reason
☐ Newborn's state of health
☐ Psychological difficulties

☐ Social difficulties
☐ Other (please specify) :

Is your baby well? ☐ Yes ☐No ☐ don't know ☐Do not wish to answer

5. Concerning breastfeeding

Have you breastfed? ☐ ☐ Yes No

If yes, how did you breastfeed?
☐ Exclusive
☐ Mixed
☐ Other (please specify) :

If yes, did you experience any difficulties when breastfeeding?

☐ Yes on the mother's side
☐ Yes on the child's side
☐ No

If no, was this your choice? ☐ ☐ Yes No

Are you currently breastfeeding? ☐ ☐ Yes No *(end date to be specified if breastfeeding before - Specify the end date of your breastfeeding (if day unknown, default to 01)*: __ / __ / _____

6. Follow-up

Have you consulted your GP since the birth? ☐ ☐ Yes No

Have you had home visits from a midwife? ☐ ☐ Yes No

Are you in contact with the PMI? ☐ ☐ Yes
No
If a psychiatric disorder is known or discovered at V2, for each disorder :

How would you describe the evolution of your disorder during pregnancy?

☐ Stable ☐ Improvement ☐ Deterioration

How would you describe the evolution of your disorder since the birth?

☐ Stable
☐ Improvement
☐ Deterioration

Concerning psychotropic treatment

Have you taken any psychotropic medication since the T2 ultrasound?

☐ Yes ☐ No ☐ Do not wish to answer

If ***yes*** - Specify the therapeutic class and

- ☐ Anxiolytic :
- ☐ Hypnotic :
- ☐ Anti-depressant :
- ☐ Thymoregulator :
- ☐ Antipsychotic :
- ☐ Other :

For each drug mentioned by the patient, ask the following questions

Who prescribed these treatments?

- ☐ General practitioner
- ☐ Psychiatrist
- ☐ Other (please specify) :

If yes, fill in the following table regarding changes in treatment since the pregnancy was planned.
Put 0 in the case of initiation or cessation of treatment.
Specify who was responsible for the change (e.g. doctor, patient, family, etc).

Before		**Date**	**After**		**Initiator**	**Reason**
Molecule	**Dosage**		**Molecule**	**Dosage**		

7. +Time taken to complete the simplified EPICES score + Paykel MINI inventory + CSSR-S

For the attending physician (at V3) :

Name of treating physician :

Attending physician wishes to participate in the study :

Now that the patient has given birth, have you seen her in consultation since she gave birth ☐ ☐ Y es No

Have you screened for post-partum depression? ☐ ☐ Yes No

If yes, was the result in favour of post-partum depression? ☐ ☐ Yes No

If yes, did you put her in touch with a professional specialising in perinatal psychiatry/psychology? ☐ ☐ Yes No

If yes, what type? ☐ ☐ ☐ ☐ Psychiatrist Psychologist Midwife Nursery nurse

Since the birth, have you entered a new psychiatric diagnosis in the patient's file? ☐ ☐ Yes No

If yes, specify the disorder: _____