

LAMOTRIGINE PREGNANCY REGISTRY REGISTRATION FORM

FOR OFFICE USE ONLY

Page 1 of 2

Registry ID _____ HCP ID _____

WSP ID _____ Country _____

Registry date of notification _____ day _____ month _____ year Phone Transcribed

Return by FAX to: 800-800-1052 (US, Canada)
910-256-0637 (All International Faxes)

Patient (Log) ID: _____

Registry-assigned ID number. Call / Fax the Registry Office for a non-patient identifying number (800-336-2176 US / Canada, 910-256-0549 Int'l, phone) 800-800-1052 US / Canada, 910-256-0637 Int'l, Fax)

Note: To help assure patient confidentiality the Registry uses a Registry-assigned patient ID to refer to your patient to obtain follow-up and outcome information. A patient log will be sent to you, if this is your first registrant. The Log will help cross-reference this ID with your own identifier(s) for this patient. Keep the log in a secure place.

MATERNAL DATA

Race White Black Hispanic Patient Age _____
 Asian Other

If patient is included in another Registry, please specify EURAP North American AED
 Other _____

Is there evidence of a defect from a prenatal test?

Yes No

If yes, indicate which test(s) showed evidence of birth defect

Ultrasound Amniocentesis
 MSAFP Other: _____

Last Menstrual Period _____

_____ day _____ month _____ year

Estimated Date of Delivery _____

_____ day _____ month _____ year

How was the Estimated Date of Delivery determined?

by Last Menstrual Period by Ultrasound

by Other Method: _____

ALL LAMOTRIGINE DOSES DURING THIS PREGNANCY

INDICATION Epilepsy Bipolar Disorder Other

	Course Began (d/m/y)	Daily Dose (total mg/day)	Course Began* (gestation week from LMP)	Course Ended (gestation week from LMP)	If Ongoing (√)
Course 1	____	_____	_____	_____	<input type="checkbox"/>
Course 2	____	_____	_____	_____	<input type="checkbox"/>
Course 3	____	_____	_____	_____	<input type="checkbox"/>

* If Course 1 began prior to conception, enter 0

HEALTH CARE PROVIDER INFORMATION

Name _____

Specialty _____

Address _____

Phone _____

Fax _____

Alternate Contact _____

Provider's Signature _____

Date _____
_____ day _____ month _____ year

Lamotrigine Pregnancy Registry — Registration Form

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OTHER ANTIEPILEPTIC/PSYCHOTROPIC DRUGS (within 1 month of conception or during this pregnancy)

Other Antiepileptic/ Psychotropic Drugs (✓ and include total dose for all that apply)	Trimester of Pregnancy							
	Prior to Conception		First Trimester		Second Trimester		Third Trimester	
	(√)	Total Daily Dosage (mg/day)	(√)	Total Daily Dosage (mg/day)	(√)	Total Daily Dosage (mg/day)	(√)	Total Daily Dosage (mg/day)
amitriptyline (Elavil)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
bupropion (Wellbutrin)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
carbamazepine (Tegretol)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
citalopram (Celexa)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
clomipramine (Anafranil)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
clonazepam (Klonopin)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
clozapine (Clozaril)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
diazepam (Valium)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
ethosuximide (Zarontin)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
felbamate (Felbatol)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
fluoxetine (Prozac)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
gabapentin (Neurontin)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
haloperidol (Haldol)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
lithium	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
olanzapine (Zyprexa)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
paroxetine (Paxil)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
phenobarbital	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
phenytoin (Dilantin)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
primidone (Mysoline)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
quetiapine (Seroquel)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
risperidone (Risperdal)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
sertraline (Zoloft)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
topiramate (Topamax)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
trimethadione (Tridione)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
valproate (Depakote)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
venlafaxine (Effexor)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
vigabatrin (Sabril)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
other: _____	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	