Visit Not Done	
Visit Not Done Reason	Not Collected Due to the Impact of Covid-19 Pandemic ☐ Inadvertently Omitted ☐ Visit Scheduling Time Constraints ☐ Subject Non-Compliant/Refusal ☐ Caregiver Non-Compliant/Refusal ☐ Subject Discontinued from Study ☐
Visit Date (dd-mon-yyyy)	
Type of Visit Performed	Study Site (Assigned or Alternate) In-Person ☐ Home Health In-Person ☐ Remote - Audio Only (e.g. Telephone) ☐ Remote - Audio and Video (e.g. Telemedicine) ☐

In addition to completing the forms for this visit, please add and/or update log records (Adverse Events, Concomitant Medications/Treatments, etc.), as appropriate

Biogen Form Version	VISIT_FV2.1

Date of Assessment (dd-mon-yyyy) _____

Source of Information
- Subject ☐
- Neurologist ☐
- Pediatrician ☐
- Obstetrician ☐
- Gynaecologist ☐
- General Medicine Physician/Internist ☐
- Medical Records ☐
- Other ☐

Other Source of Information _____

First Date of Last Menstrual Period (LMP) (dd-mon-yyyy) _____

Estimated Date of Delivery (EDD) (dd-mon-yyyy) _____

How was Current Pregnancy Confirmed? (Check all that Apply)

Urine Pregnancy Test _____

Date of Test (dd-mon-yyyy) _____

Pelvic/Abdominal Physical Exam _____

Date of Test (dd-mon-yyyy) _____

Laboratory Blood Test _____

Date of Test (dd-mon-yyyy) _____

Ultrasound _____

Date of Test (dd-mon-yyyy) _____

Fetal Heart Tones by Auscultation or Doppler _____

Date of Test (dd-mon-yyyy) _____

Other Test _____

If Other Test, Please Specify _____

Date of Test (dd-mon-yyyy) _____

Was there any change in the Prenatal Testing since previous assessment?	Yes ☐ No ☐
Has any Prenatal Testing beyond Confirmatory Tests of Pregnancy been Completed?	Yes ☐ No ☐ Unknown ☐
Source of Information	Subject ☐ Neurologist ☐ Pediatrician ☐ Obstetrician ☐ Gynaecologist ☐ General Medicine Physician/Internist ☐ Medical Records ☐ Other ☐
If Other Source of Information, Please Specify	_____
If more than one test is performed, add multiple rows	
Test	Ultrasound ☐ Amniocentesis ☐ MSAFP/Serum ☐ Other ☐
Date of Test (dd-mon-yyyy)	_____
Date of Test Results(dd-mon-yyyy)	_____
Evidence of Abnormality	Yes ☐ No ☐ Unknown ☐
If Yes, Please Specify	_____

272MS401_eCRF_EditChecks_Database_Validation_0.1: All Visits
Project Name: 272MS401
Folder: Prenatal Follow-Up at 6 to 7 Months of Gestation
Form: Vital Signs Follow-Up
Generated On: 10 Jul 2023 16:06:42

Vital Signs Assessment Date (dd-mon-yyyy)	_____
Weight	_____
Weight Unit	kg ☐ lb ☐
Weight Difference Since Last Visit	_____
Weight Unit	KG
Biogen Form Version	VS_FV1.0

272MS401_eCRF_EditChecks_Database_Validation_0.1: All Visits
Project Name: 272MS401
Folder: Prenatal Follow-Up at 6 to 7 Months of Gestation
Form: Pregnancy Status Since Last Contact
Generated On: 10 Jul 2023 16:06:42

Is the Subject Currently Pregnant at the time of the Follow-Up?	Yes ☐ No ☐ Unknown ☐
If No, Please Complete Pregnancy Outcome Form	
If Yes, Provide the Estimated Gestational Age (Weeks)	_____
Date of Assessment (dd-mon-yyyy)	_____
Source of Information	Subject ☐ Neurologist ☐ Pediatrician ☐ Obstetrician ☐ Gynaecologist ☐ General Medicine Physician/Internist ☐ Medical Records ☐ Other ☐
Other Source of Information	_____

272MS401_eCRF_EditChecks_Database_Validation_0.1: All Visits
Project Name: 272MS401
Folder: Prenatal Follow-Up at 6 to 7 Months of Gestation
Form: MS Disease Changes Since Last Contact
Generated On: 10 Jul 2023 16:06:42

Has the Subject's MS Disease Course Changed or has the Subject had a Relapse Since Last Contact?	Yes ☐ No ☐
Please Indicate the Number of MS Relapses Since the Last Contact	_____
Current MS Status	Active ☐ Relapse ☐ Progressing ☐ Other ☐
If Other MS Status, Please Specify	_____

Did the Subject have any Other Pregnancy Risk Factors?	Yes ☐ No ☐
Date of Assessment (dd-mon-yyyy)	_____
Source of Information	Subject ☐ Neurologist ☐ Pediatrician ☐ Obstetrician ☐ Gynaecologist ☐ General Medicine Physician/Internist ☐ Medical Records ☐ Other ☐
Other Source of Information	_____
Alcohol Use	Yes ☐ No ☐
Alcohol Use History	Before Pregnancy ☐ During Pregnancy ☐
Type of Beverage	Beer ☐ Wine ☐ Liquor/Spirits ☐ Other ☐
If Other, Please Specify	_____
Volume	_____
Unit	mL ☐ oz ☐
Frequency	Daily ☐ Weekly ☐ Monthly ☐
Tobacco Use	Yes ☐ No ☐
Type of Product	Cigarettes ☐ Cigars ☐

	Pipes ☐ Smokeless Tobacco ☐ eCigarette/Vaporizer ☐ Hookah ☐ Other ☐
If Other, Please Specify	_____
Average Quantity	_____
Unit	Number of Cigarettes ☐ Number of Cigars ☐ Number of Pipes ☐ Pinch/Snuff ☐ Number of Inhalations ☐ Number of Bowls ☐ Other ☐
If Other, Please Specify	_____
Frequency	Daily ☐ Weekly ☐ Monthly ☐
Does the Subject use Tobacco/ENDS (Electronic Nicotine Delivery Systems)?	Yes ☐ No ☐
Tobacco/ ENDS (Electronic Nicotine Delivery Systems) Use History	Before Pregnancy ☐ During Pregnancy ☐
Year of Subject Started using Tobacco/ ENDS (yyyy)	_____
Year of Subject Stopped using Tobacco/ENDS (Before Pregnancy Only) (yyyy)	_____
Does the Subject use Caffeine?	Yes ☐ No ☐
Caffeine Use History	Before Pregnancy ☐ During Pregnancy ☐
Year of Subject Started using Caffeine (yyyy)	_____
About how many Caffeinated Beverages per day (on Average)?	Less Than 8 oz ☐ More Than 8 oz ☐

	Other ☐
Year of Subject Stopped using Caffeine (Before Pregnancy Only) (yyyy)	_____
Does the Subject use Recreational Drug?	Yes ☐ No ☐
Recreational Drug Use History	Before Pregnancy ☐ During Pregnancy ☐
If Before Pregnancy/During Pregnancy, Please Specify Drug Name	_____
Year of Subject Started using Recreational Drugs (yyyy)	_____
Year of Subject Stopped using Recreational Drug (Before Pregnancy Only) (yyyy)	_____