

PREGNANCY SUMMARY

A waiver request for pregnancy requires completion of this form and should be uploaded into AERO in addition to creating an AMS in AERO. The LBFS may issue a temporary 90-day up-chit to occur between the 12th (or once a viable singleton intrauterine pregnancy is confirmed by ultrasound) and 30th week, provided the pregnancy and medical conditions are uncomplicated. Contact NAMI for consideration of 90-day LBFS upchit for pregnancies with other conditions.

Date: _____ **Service:** _____ **Rank:** _____ **Age:** _____
Last Name: _____ **First Name:** _____ **MI:** _____ **SSN:** _____
OB Care Provider: _____ **Date OB Intake:** _____
Provider Email: _____ **Provider Phone No.:** _____

Expiration Date of Aviation Physiology Qualification - _____

* Performing aviation physiology qualification training during pregnancy is prohibited (CNAF M- 3710.7 series).

Gravida: _____ **Parity:** _____ **SAb:** _____

Previous Pregnancy Complications: _____

Other Medical Conditions/Waivers: _____

Meds:

Allergies:

ROS:	Y	N		Y	N		Y	N
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Dyspnea	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Vision Changes	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Dysuria	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Flank Pain	<input type="checkbox"/>	<input type="checkbox"/>

VS Temp: _____ **HR:** _____ **BP:** _____

Visual Acuity: **Y** **N**

Is/Corrects to 20/20 OD	<input type="checkbox"/>	<input type="checkbox"/>	If vision does not correct to 20/20, waiver will not be considered and optometry referral is needed.
Is/Corrects to 20/20 OS	<input type="checkbox"/>	<input type="checkbox"/>	
Is/Corrects to 20/20 OU	<input type="checkbox"/>	<input type="checkbox"/>	

US#1: Date: _____ **US EDC:** _____ **Intrauterine:**
Singleton:

Comments:

Other US: Date: _____ **US EDC:** _____ **Normal:**

Comments:

<u>Test</u>	<u>Value</u>	<u>Test</u>	<u>Value</u>
WBC		FBS	
Hgb/Hct		UA	
Platelets			

** Any abnormal labs must be discussed in flight surgeon comments section **

Date pregnancy reaches: 12 weeks: _____ 30 weeks: _____

Estimated Delivery Date (EDC): _____ Estimated Return to Full Duty: _____

Flight Surgeon Comments:

Summary/Disposition: Class I (SG 1, 2, 3), II, III; _____ ; @ _____ weeks gestation

PQ/AA for pregnancy, uncomplicated Class III IV

uncomplicated NPQ/AA for all aviation Duties

* Any waiver must be IAW CNAF M- 3710.7 series - flying while pregnant is prohibited in:

* high performance aircraft operating in excess of 2 Gs

* cabin altitude exceeding 10,000 feet

Pregnancy, Uncomplicated (V22)

Waiver Recommended: Class I (SG3), II,

Pregnancy, Uncomplicated (V22), with Other Medical Conditions/Waivers

Others Conditions/Waivers _____ (Attach Notes)

Waiver Recommended: Class I (SG3), II, III, IV, V defer to NAMI for final disposition

LBFS upchit discussed with NAMI _____

Pregnancy, Complicated (630-650)

Waiver Recommended, defer to NAMI for final disposition, 90-day upchit not authorized

Waiver NOT RECOMMENDED. (Only unit flight surgeon signature required.)

Waiver NOT REQUESTED. (Only unit flight surgeon signature required.)

Member has been educated on the potential risks of continued flying during pregnancy.

Request to Continue Flying While Pregnant: reviewed and signed (attached).

Member understands to return to her flight surgeon should any symptoms develop.

LBFS upchit issued with CO concurrence (up to 28th week). Pilot in

Pilot in Command is authorized IAW - OPNAVINST 3710.7 series

Command endorsement: the member's commanding officer is aware and concurs with this member's diagnosis, prognosis, waiver requirements and waiver recommendation in this Aeromedical Summary.

LBFS Signatures:

Unit Flight Surgeon _____ Date: _____

Flight Surgeon _____ Date: _____

Obstetric Provider _____ Date: _____