Form Approved
OMB Control No.: 0920-XXXX
Expiration date: XX/XX/XXXX

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Pregnancy and Zika virus disease surveillance form

These data are considered confidential and will be stored in a secure database at the Centers for Disease Control and Prevention

Please return completed form by fax to (970) 266-3568 or email XXXX@cdc.gov

Infant follow up: ☐ 2 months ☐ 6 months ☐ 12 months

Infant's name: _____ **Date of exam:** ____/____/____

Weight: _____ ☐ kg ☐ lbs/oz **Length:** _____ ☐ cm ☐ in **Head circum:**_____ ☐ cm ☐ in

Infant physical exam: ☐ Normal ☐ Abnormal *(please describe)*

Infant development: ☐ Normal ☐ Abnormal *(please describe)*

Special Studies Since Last Follow-Up

(Please summarize any results)

CT/other imaging scan: ☐ Yes ☐ No

Hearing evaluation performed: ☐ Yes ☐ No

Dysmorphology exam: ☐ Yes ☐ No

Ophthalmologic exam: ☐ Yes ☐ No

Other *(please describe)*: ☐ Yes ☐ No

Provider Information

Provider name: ☐ Dr. ☐ PA ☐ RN ☐ Mr. ☐ Ms. **Phone:** _____
_____ **Email:** _____

Name of person completing form: ***(if different from provider)*** **Hospital/facility:** _____
_____ _____
_____ **Phone:**_____

FOR INTERNAL CDC USE ONLY
Mother ID: **State ID:**