



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:** _____

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Mother ID: _____ **State ID:** _____

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX)