# 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 sending an encrypted email to ZIKApregnancy@cdc.gov or by fax to the secure number: 404-718-2200. Pregnancy & Birth Defects Task Force phone number: 770-488-7100**

## Mother's Zika virus infection (ADB follow-up)

**Mother's name:** _____ **Last** **First** **MI**

_____ Maiden name *(if applicable)*

**State/Territory ID:** _____

**DOB:** _____/_____/_____

**State/Territory of residence:** _____

**County of residence:** _____

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

**Race** *(check all that apply)*: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or other Pacific Islander ☐ White

**Indication for maternal Zika virus testing:** ☐ Exposure history, no known fetal concerns ☐ Exposure history and fetal concerns

**Date of Zika virus symptom onset:** _____/_____/_____ **OR-** ☐ Asymptomatic

*If date not known, trimester of symptom onset* _____

**Hospitalized** for Zika virus disease ☐ No ☐ Yes Maternal Death ☐ No ☐ Yes

Symptoms of mother's Zika virus disease: *(check all that apply)*
☐ Fever _____°F (*if measured*) ☐ Rash ☐ Arthralgia ☐ Conjunctivitis
☐ Other Clinical Presentation_____

**If symptomatic, gestational age at onset:** _____weeks

*If gestational age not known ,trimester of symptom onset* _____

**Travel history:** ☐ No ☐ Yes

**Was Zika virus infection acquired in place of residence** ☐ No ☐ Yes, *if yes, skip to the section on Mother's pregnancy*

**If TRAVEL DURING PREGNANCY, answer questions below. If not, skip to non-traveling woman**

**Country(s) of exposure (1)**_____ **Travel start** _____/_____/_____ **Travel end**_____/_____/_____

Mother's sexual partner(s)? *please check all that apply* ☐ Male ☐ Female

Did any male sexual partner(s) travel on this trip? ☐ No ☐ Yes ☐ Unknown

If yes, did any male partner(s) have an illness that included fever, rash, arthralgia, or conjunctivitis during or within 2 weeks of travel? ☐ No ☐ Yes ☐ Unknown

If yes, was there unprotected sexual contact while male partner(s) had illness? ☐ No ☐ Yes ☐ Unknown

If male partner(s) traveled, did he have a test that showed lab evidence of Zika? ☐ No ☐ Yes ☐ Unknown

**Country(s) of exposure (2)**_____ **Travel start** _____/_____/_____ **Travel end**_____/_____/_____

Mother's sexual partner(s)? *please check all that apply* ☐ Male ☐ Female

Did any male sexual partner(s) travel on this trip? ☐ No ☐ Yes ☐ Unknown

If yes, did any male partner(s) have an illness that included fever, rash, joint pain, or pink eye during or within 2 weeks of travel? ☐ No ☐ Yes ☐ Unknown

If yes, was there unprotected sexual contact while male partner(s) had illness? ☐ No ☐ Yes ☐ Unknown

If male partner(s) traveled, did he have a test that showed lab evidence of Zika? ☐ No ☐ Yes ☐ Unknown

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| **Country(s) of exposure (3)**_____ | **Travel start** _____/_____/_____ | **Travel end**_____/_____/_____ |
|---|---|---|

Mother's sexual partner(s)? *please check all that apply* ☐ Male ☐ Female

Did any male sexual partner(s) travel on this trip? ☐ No ☐ Yes ☐ Unknown

If yes, did any male partner(s) have an illness that included fever, rash, joint pain, or pink eye during or within 2 weeks of travel? ☐ No ☐ Yes ☐ Unknown

If yes, was there unprotected sexual contact while male partner(s) had illness? ☐ No ☐ Yes ☐ Unknown

If male partner(s) traveled, did he have a test that showed lab evidence of Zika? ☐ No ☐ Yes ☐ Unknown

**NON-TRAVELLING WOMAN: other possible exposures?**

☐ Sexual partner w/travel history, symptomatic, lab evidence of Zika
☐ **Sexual partner w/travel history, symptomatic, no test results**
☐ Sexual partner w/travel history, asymptomatic, lab evidence Zika
☐ Other, please describe_____
☐ Unknown exposure history

## Mother's pregnancy (DRH/DBDDD follow-up)

| Last menstrual period (LMP): _____/_____/_____ | Estimated delivery date: _____/_____/_____ |
|---|---|

Estimated delivery date based on (***check all that apply***): ☐ LMP ___/___/___ ☐ U/S (1st trimester) ☐ U/S (2nd trimester) ☐ U/S (3rd trimester)

History: **# pregnancies** _____ **# living children** _____ **# miscarriages** _____ **# elective terminations** _____

**Prior fetus/infant with microcephaly: ☐ No ☐ Yes If yes, genetic cause: ☐ No ☐ Yes**

**Gestation:** ☐ Single ☐ Twins ☐ Triplets+

**Underlying maternal illness:**
Diabetes ☐ No ☐ Yes Maternal PKU ☐ No ☐ Yes Hypothyroidism ☐ No ☐ Yes Hypertension ☐ No ☐ Yes
Substance use during this pregnancy: Alcohol use ☐ No ☐ Yes Cocaine use ☐ No ☐ Yes Smoking ☐ No ☐ Yes
Other underlying illness: _____

**Complications of pregnancy:**
Toxoplasmosis ☐ Negative ☐ Positive ☐ Unknown Cytomegalovirus ☐ Negative ☐ Positive ☐ Unknown
Herpes Simplex ☐ Negative ☐ Positive ☐ Unknown Rubella ☐ Negative ☐ Positive ☐ Unknown
Syphilis ☐ Negative ☐ Positive ☐ Unknown

Fetal genetic abnormality ☐ No ☐ Yes, *diagnosis* _____ ☐Unknown
Gestational diabetes ☐ No ☐ Yes Pregnancy-related HTN ☐ No ☐ Yes Intrauterine death of a twin ☐ No ☐ Yes
Other _____

**Medications during pregnancy:** ☐ No ☐ Yes (*please list type and see guide for further instructions)*_

| **Did this pregnancy end in miscarriage or intrauterine fetal demise (IUFD)?** ☐ No ☐ Yes *Date:* _____/_____/_____ | **Was this pregnancy terminated?** ☐ No ☐ Yes *Date:* _____/_____/_____ |
|---|---|

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| *Gestational age_____ weeks* | *Gestational age_____ weeks* |
|---|---|

## Maternal Prenatal Imaging and Diagnostics

| **Date(s) of Ultrasound(s):** | |
|---|---|
| ____/____/____<br>☐ *check if date approximated if date not known, gestational age _____ weeks* | **Overall Fetal Ultrasound Results:** ☐ Normal ☐ Abnormal<br>☐ *reported by patient/healthcare provider* ☐ ultrasound report<br><br>Head Circumference _____cm ☐ Normal ☐ Abnormal (*by physician report*)<br>Biparietal diameter _____cm Femur Length _____cm Abdominal circumference _____cm<br>☐ Symmetrical intrauterine growth restriction (IUGR) (<5% EFW)<br>☐ Asymmetrical IUGR (HC<FL or HC <AC) |
| | Intracranial calcifications ☐ No ☐ Yes Ventriculomegaly ☐ No ☐ Yes |
| | Cerebral atrophy ☐ No ☐ Yes Ocular anomalies ☐ No ☐ Yes |
| | Cerebellar abnormalities ☐ No ☐ Yes Arthrogryposis ☐ No ☐ Yes |
| | Lissencephaly ☐ No ☐ Yes Pachygyria ☐ No ☐ Yes<br>Hydranencephaly ☐ No ☐ Yes Porencephaly ☐ No ☐ Yes<br>Corpus callosum abnormalities ☐ No ☐ Yes Hydrops ☐ No ☐ Yes |
| | Ascites ☐ No ☐ Yes Other ☐ No ☐ Yes, describe |
| **Description of abnormal ultrasound findings:** | |

| | |
|---|---|
| ____/____/____<br>☐ *check if date is approximated if date not known, gestational age _____ weeks* | **Overall Fetal Ultrasound Results:** ☐ Normal ☐ Abnormal<br>☐ *reported by patient/healthcare provider* ☐ ultrasound report<br><br>Head Circumference _____cm ☐ Normal ☐ Abnormal (*by physician report*)<br>Biparietal diameter _____cm Femur Length _____cm Abdominal circumference _____cm<br>☐ Symmetrical IUGR (<5% EFW) ☐ Asymmetrical IUGR (HC<FL or HC <AC) |
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| | Cerebral atrophy ☐ No ☐ Yes Ocular anomalies ☐ No ☐ Yes |
| | Cerebellar abnormalities ☐ No ☐ Yes Arthrogryposis ☐ No ☐ Yes |
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| | Ascites ☐ No ☐ Yes Other ☐ No ☐ Yes, describe |
| **Description of abnormal ultrasound findings:** | |

| | |
|---|---|
| ____/____/____<br>☐ *check if date* | **Overall Fetal Ultrasound Results:** ☐ Normal ☐ Abnormal<br>☐ *reported by patient/healthcare provider* ☐ ultrasound report<br><br>Head Circumference _____cm ☐ Normal ☐ Abnormal (*by physician report*) |

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| | |
|---|---|
| *is approximated if date not known, gestational age* _____ *weeks* | Biparietal diameter _____cm Femur Length _____cm Abdominal circumference _____cm<br>☐ Symmetrical IUGR (<5% EFW) ☐ Asymmetrical IUGR (HC<FL or HC <AC) |
| | Intracranial calcifications ☐ No ☐ Yes Ventriculomegaly ☐ No ☐ Yes |
| | Cerebral atrophy ☐ No ☐ Yes Ocular anomalies ☐ No ☐ Yes |
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| | Ascites ☐ No ☐ Yes Other ☐ No ☐ Yes, describe |

**Description of abnormal ultrasound findings:**

**For additional ultrasounds, please request a supplementary ultrasound form**

**Fetal MRI performed:** ☐ No ☐ Yes (*please answer questions below*)

| | |
|---|---|
| ____/____/____<br>☐ *check if date is approximated*<br><br>*if date not known, gestational age* _____ *weeks* | **Overall Fetal MRI Results:** ☐ Normal ☐ Abnormal<br>☐ *reported by patient/healthcare provider* ☐ ultrasound report<br><br>Head Circumference ___cm ☐ Normal ☐ Abnormal (*by physician report*)<br>Biparietal diameter _____cm Femur Length _____cm Abdominal circumference _____cm<br>☐ Symmetrical IUGR (<5% EFW) ☐ Asymmetrical IUGR (HC<FL or HC <AC) |
| | Intracranial calcifications ☐ No ☐ Yes Ventriculomegaly ☐ No ☐ Yes |
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| | Ascites ☐ No ☐ Yes Other ☐ No ☐ Yes, describe |

**Description of abnormal MRI findings:**

**Amniocentesis performed:** ☐ No ☐ Yes *(date: _____/_____/_____ )*

Zika virus testing: ☐ Not performed ☐ Yes, *if yes test results:* ☐ negative for Zika ☐ lab evidence of Zika
Non-Zika infection detected ☐ No ☐ Yes *if yes, what infection(s) detected*_____
Genetic abnormality detected ☐ No ☐ Yes *Please Describe:*_

## Provider Information

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

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Last First MI

**Phone:** _____ **Email:** _____ **Date of form completion**__ __ __ __/__ __ __ __/__ __ __ __

**Name of person completing form:** ***(if different from provider)*** _____

Last First MI

**Hospital/ facility:**_____

**Phone:** _____ **Email:** _____ **Date of form completion**__ __ __ __/__ __ __ __/__ __ __ __

## Health Department Information

**Name of person completing form:**

_____

**Phone:** _____ **Email:** _____ **Date of form completion**__ __ __ __/__ __ __ __/__ __ __ __

**FOR INTERNAL CDC USE ONLY**

**Mother ID:** **State/Territory ID:** **Zika T ID:**

**R number**: _____ **Mother infection type:** ☐ Confirmed ☐ Probable ☐ Possible