



## 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](mailto:ZIKApregnancy@cdc.gov) or by fax to the secure number: 404-718-2200. Pregnancy & Birth Defects phone number: 770-488-7100**

<i>(please describe)</i>	<i>(please describe)</i>	<i>(please describe)</i>
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**Other abnormalities identified:** *(please provide clinical description from medical records and include chromosomal abnormalities and syndromes); please check all that apply*

- Microphthalmia       Absent red reflex       Excessive and redundant scalp skin   
 Arthrogryposis (congenital joint contractures)       Congenital Talipes Equinovarus (clubfoot)  
 Other abnormalities *(please describe below)*

### Neonate Imaging and Diagnostics

**Hearing screening :** *(date: \_\_\_\_/\_\_\_\_/\_\_\_\_)*  Pass     Fail or referred     Not performed  
*(please describe below)*

**Retinal exam (with dilation):**     Not Performed     Unknown

*If performed: (date: \_\_\_\_/\_\_\_\_/\_\_\_\_) please check all that apply:*

- Microphthalmia     Chorioretinitis     Macular pallor     Other retinal abnormalities *(please describe below)*

**Imaging study:**  Cranial ultrasound *(date: \_\_\_\_/\_\_\_\_/\_\_\_\_)*       MRI *(date: \_\_\_\_/\_\_\_\_/\_\_\_\_)*  
 CT *(date: \_\_\_\_/\_\_\_\_/\_\_\_\_)*       Not Performed

**Findings:** *check all that apply*

- Microcephaly     Cerebral (brain) atrophy     Intracranial calcification     Ventricular enlargement  
 Lissencephaly     Pachygyria     Hydranencephaly     Porencephaly      
 Abnormality of corpus callosum     Other abnormalities *(please describe below)*

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 CT *(date: \_\_\_\_/\_\_\_\_/\_\_\_\_)*       Not Performed

**Findings:** *check all that apply*

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Abnormality of corpus callosum  Other abnormalities (please describe below)

**Imaging study:**  Cranial ultrasound (date: \_\_\_\_/\_\_\_\_/\_\_\_\_)  MRI (date: \_\_\_\_/\_\_\_\_/\_\_\_\_)  
 CT (date: \_\_\_\_/\_\_\_\_/\_\_\_\_)  Not Performed

**Findings:** check all that apply

Microcephaly     Cerebral (brain) atrophy     Intracranial calcification     Ventricular enlargement  
 Lissencephaly     Pachygyria     Hydranencephaly     Porencephaly   

Abnormality of corpus callosum  
 Other abnormalities (please describe below)

**Was a lumbar puncture performed:**  Yes  No  Unknown (date: \_\_\_\_/\_\_\_\_/\_\_\_\_)

**Congenital Infection Testing:** if performed, please specify test (i.e. PCR, IgG, IgM)

	Toxoplasmosis	Cytomegalovirus	Herpes Simplex	Rubella	Other
Positive					
Negative					
Not Done					
Date					

**Other tests/results/diagnosis (include dates):**

### Provider Information

**Neonatal Provider name:**  Dr.  PA  RN  Mr.  Ms. \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_ **Date of form completion** \_\_\_\_\_  
 \_\_\_\_/\_\_\_\_/\_\_\_\_

**Pediatric Provider name:**  Dr.  PA  RN  Mr.  Ms. \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

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

**Hospital/facility:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Name of Infant Pediatrician:** \_\_\_\_\_

Infant's State/Territory ID \_\_\_\_\_ Mother's State/Territory ID \_\_\_\_\_  
Approved

OMB No. 0920-1101  
Exp. 08/31/2016

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Phone: _____ Email: _____ Date of form completion _____ _____/_____/_____
<b>Health Department Information</b>
Name of person completing form: _____
Phone: _____ Email: _____ Date of form completion _____ _____/_____/_____
<b>FOR INTERNAL CDC USE ONLY</b>
Mother ID: _____ State/territory ID: _____
<small>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 (0920-1101)</small>