

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 <u>ZIKApregnancy@cdc.gov</u> or by fax to the secure number: 404-718-2200. Pregnancy & Birth Defects phone number: 770-488-7100

Neonate Assessment								
Infant's name:								Birth Certificate ID:
Last	First			ΜI				
Infant's State/Territory ID	Mother's State/Territo	ory ID	DOB:	/	/	Sex: ☐ Ma		☐ Female uous/undetermined
Based on: (check all that apply) / □ U/S (1 st trimester) trimester) □ U/S (3 rd trimester) Gestational age at delivery: weeks days					nester) \square U/S (2 nd ester) \square			
State/Territory of resid	dence:							
Delivery type: □ Vagi	nal 🗆 Caes	arean section	า		Arterial Cor	d blood pH:	if p	erformed
Delivery complication:	□ No □ Yes							
If yes,					Venous Core	ous Cord blood pH: if performed		
Placental exam (based on path report): ☐ No ☐ Yes If yes, ☐ Normal ☐ Abruption ☐ Inflammation ☐ Other abnormality (please describe)								
Apgar score: 1 min	/ 5 mir	l			Infant temp	(if abnorm	al): _	°F
Physical Examination								
Birth head circumference: cm Birth weight: grams cm cm in lbs/oz in in lbs/oz in lbs/oz in in lbs/oz in lbs/oz lbs/oz in lbs/oz								
Repeat head circumference: □ cm □ in Admitted to Neonatal Intensive Care Unit: □ < 24hrs								
Microcephaly (head circumference <3%ile): ☐ No ☐ Yes Seizures: ☐ No ☐ Yes								
Neurologic exam: check all that apply □ Not performed □ Unknown □ Normal □ Hypertonia/Spasticity □ Hyperreflexia □ Irritability □ Tremors □ Other Neurologic abnormalities (please describe below)								
Splenomegaly by physical exam: Hepatomegaly by ph □ No □ Yes □ Unknown □ No □ Yes □ Unknown			-				hysical exam: □ Unknown	

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Infant's	State/	Territory	IL

	c /m .	
Mother's	State/Territory	H)

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

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(please describe)	(please describe)	(please describe)			
-	ease provide clinical description from n	nedical 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)					
	leanate Imaging and Diagnost	ice			
	leonate Imaging and Diagnost				
Retinal exam (with dilation): □ If performed: (date://_ □ Microphthalmia □ Chorioretin below)		abnormalities (please describe			
Imaging study: ☐ Cranial ultrasour☐ CT (date: Findings: check all that apply		□ MRI <i>(date:</i> /) Not Performed			
☐ Microcephaly ☐ Cerebral (bra☐ Lissencephaly ☐ Pachygyria Abnormality of corpus callosum	nin) atrophy □ Intracranial calcificat □ Hydranencephaly □ Other abnormalities (<i>ple</i>	☐ Porencephaly ☐			
Imaging study: ☐ Cranial ultrasour☐ CT (date: Findings: check all that apply		□ MRI (date:/) Not Performed			
☐ Microcephaly ☐ Cerebral (bra☐ Lissencephaly ☐ Pachygyria	ain) atrophy □ Intracranial calcificat □ Hydranencephaly	ion □ Ventricular enlargement □ Porencephaly □			

Infant's	State/	Territory	, ID
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Abnormality of corpus callosum						
		und (date:/_			e:/	_)
	CT (date:	/)	L	☐ Not Perform	ned	
Findings: check				=		_
1	Cerebral (b		ntracranial calcific		ntricular enlargemen [.] encephaly	_
Abnormality of o	Pachygyria	шп	ydranencephaly		епсерпату	П
	nalities (please de	scribe helow)				
- Other abriorn	ianties (piease ae.	seribe below)				
Was a lumbar p	uncture performe	d: ? Yes ? No ? Unk	nown (date:	/ /)	
		performed, please s			/	
	Toxoplasmosis	Cytomegalovirus		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/	Hospital/					
facility:		Phone:				
Name of Infant	Pediatrician:					

Infant's State/Territory ID		Mother's State/Territory ID	
	Approved	-	

burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-1101)

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Phone:	Email:	Date of form completion_
	Health Department I	nformation
Name of person completin	g form:	
Phone:	Email:	Date of form completion_
//		
FOR INTERNAL CDC USE ONLY		
Mother ID:	State/territory I	D:
maintaining the data needed, and completing and	reviewing the collection of information. An agency may not cor	ng the time for reviewing instructions, searching existing data sources, gathering and iduct or sponsor, and a person is not required to respond to a collection of information ther aspect of this collection of information, including suggestions for reducing this