



## 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

Infant follow up: <input type="checkbox"/> 2 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months			
Infant's name: _____			Date of infant examination ____/____/____
Last First MI			
Infant's State/Territory ID _____	Mother's State/Territory ID _____	DOB: ____/____/____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous/undetermined
Infant Death: <input type="checkbox"/> No <input type="checkbox"/> Yes, date ____/____/____ <input type="checkbox"/> Unknown			
Weight: _____ <input type="checkbox"/> grams _____ <input type="checkbox"/> lbs/oz	Length: _____ <input type="checkbox"/> cm _____ <input type="checkbox"/> in	Head circumference _____ <input type="checkbox"/> cm _____ <input type="checkbox"/> in	
Infant findings for corrected age at examination: (For infants born preterm, please account for corrected age: chronological age minus weeks born before 40 weeks gestation)			
<b>Check all that apply</b>			
<input type="checkbox"/> Microcephaly (head circumference <3%ile)	<input type="checkbox"/> Excessive and redundant scalp skin		
<input type="checkbox"/> Arthrogryposis (congenital joint contractures)	<input type="checkbox"/> Congenital Talipes Equinovarus (clubfoot)		
<input type="checkbox"/> Hypertonia/Spasticity <input type="checkbox"/> Hyperreflexia	<input type="checkbox"/> Irritability <input type="checkbox"/> Tremors		
<input type="checkbox"/> Splenomegaly <input type="checkbox"/> Hepatomegaly	<input type="checkbox"/> Skin rash <input type="checkbox"/> Microphthalmia		
<input type="checkbox"/> Absent red reflex <input type="checkbox"/> Excessive and redundant scalp skin	<input type="checkbox"/> Swallowing/feeding difficulties		
<input type="checkbox"/> Congenital Talipes Equinovarus (clubfoot)	<input type="checkbox"/> Arthrogryposis (congenital joint contractures)		
Please list other abnormal findings:			
Development assessment for corrected age at examination: (For infants born preterm, please account for corrected age: chronological age minus weeks born before 40 weeks gestation)			
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown			
If developmental delay, in what area? please check all that apply			
<input type="checkbox"/> Gross motor <input type="checkbox"/> Fine motor <input type="checkbox"/> Cognitive, linguistic and communication <input type="checkbox"/> Socio-Emotional			
<b>Special Studies Since Last Follow-Up</b>			
Imaging study: <input type="checkbox"/> Cranial ultrasound (date: ____/____/____) <input type="checkbox"/> MRI (date: ____/____/____)			
<input type="checkbox"/> CT (date: ____/____/____) <input type="checkbox"/> Other _____ <input type="checkbox"/> Not Performed			
Findings: check all that apply			
<input type="checkbox"/> Microcephaly <input type="checkbox"/> Cerebral (brain) atrophy	<input type="checkbox"/> Intracranial calcification <input type="checkbox"/> Ventricular enlargement		
<input type="checkbox"/> Lissencephaly <input type="checkbox"/> Pachygyria	<input type="checkbox"/> Hydranencephaly <input type="checkbox"/> Porencephaly		
<input type="checkbox"/> Abnormality of corpus callosum	<input type="checkbox"/> Other abnormalities (please describe below)		



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

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

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

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

**Imaging study:**  Cranial ultrasound (date: \_\_\_\_/\_\_\_\_/\_\_\_\_)  MRI (date: \_\_\_\_/\_\_\_\_/\_\_\_\_)  
 CT (date: \_\_\_\_/\_\_\_\_/\_\_\_\_)  Other \_\_\_\_\_  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*)

**Hearing screening or re-screening:**  Not performed  Unknown  
*If performed: (date: \_\_\_\_/\_\_\_\_/\_\_\_\_)  Pass  Fail or referred, please describe*

**Audiological evaluation:**  Not performed  Unknown  
*If performed: (date: \_\_\_\_/\_\_\_\_/\_\_\_\_)  Normal  Abnormal, please describe*

**Retinal exam (with dilation):**  Not Performed  Unknown  
*If performed: please check all that apply: (date: \_\_\_\_/\_\_\_\_/\_\_\_\_)*  
 Microphthalmia  Chorioretinitis  Macular pallor  Other retinal abnormalities(*please describe below*)

**Other abnormal tests/results/diagnosis (include dates):**  No  Yes (date: \_\_\_\_/\_\_\_\_/\_\_\_\_)  
*please describe*

### Provider Information

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

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

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

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



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

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

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Infant follow up:  2 months  6 months  12 months

#### Health Department Information

Name of person completing form: \_\_\_\_\_

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_

#### FOR INTERNAL CDC USE ONLY

Mother ID: \_\_\_\_\_

State/territory 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 (0920-1101)