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 phone number: 770-488-7100

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

Infant's name:
_____
Last First MI

Date of infant examination
_____/_____/____

Infant's State/Territory ID
_____

Mother's State/Territory ID
_____

DOB:
_____/_____/_____

Sex: ☐ Male ☐ Female ☐ Ambiguous/undetermined

Infant Death: ☐ No ☐ Yes, date _____/_____/____ ☐ Unknown

Weight: _____ ☐grams _____ ☐ lbs/oz

Length: _____ ☐ cm _____ ☐ in

Head circumference _____ ☐ cm _____ ☐ 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)*

Check all that apply

☐ Microcephaly (head circumference <3%ile) ☐ Excessive and redundant scalp skin
☐ Arthrogryposis (congenital joint contractures) ☐ Congenital Talipes Equinovarus (clubfoot)
☐ Hypertonia/Spasticity ☐ Hyperreflexia ☐ Irritability ☐ Tremors
☐ Splenomegaly ☐ Hepatomegaly ☐ Skin rash ☐ Microphthalmia
☐ Absent red reflex ☐ Excessive and redundant scalp skin ☐ Swallowing/feeding difficulties
☐ Congenital Talipes Equinovarus (clubfoot) ☐ 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)*

☐ Normal ☐ Abnormal ☐ Unknown

If developmental delay, in what area? *please check all that apply*

☐ Gross motor ☐ Fine motor ☐ Cognitive, linguistic and communication ☐ Socio-Emotional

Special Studies Since Last Follow-Up

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*)

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Infant's State/Territory ID_____ Mother's State/Territory ID _____

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

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☐ 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**__**_____/_____/____**

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Health Department Information

Name of person completing form:

_____

Phone: _____ Email: _____ Date of form completion

_____/_____/____

FOR INTERNAL CDC USE ONLY

Mother ID: **State/territory ID:**