U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Neonate Assessment Form

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Please return completed form via SAMS or secure FTP—request access from ZIKApregnancy@cdc.gov
The form can also be sent by encrypted email to this address or by secure fax to 404-718-1013 or 404-718-2200
Contact Pregnancy & Birth Defects Task Force phone number: 770-488-7100

NAD.1. Infant's State/Territory ID _____	**NAD.2. Mother's State/Territory ID** _____	**NAD.3. DOB:** _____/_____/_____ ☐Live birth ☐Stillbirth ≥20 weeks	**NAD.4. Sex:** ☐ Male ☐ Female ☐ Ambiguous/undetermined
NAD.5. Gestational age at delivery: _____ weeks _____ days	**NAD.6. Based on: (*check all that apply*)** ☐ LMP ___/___/___ ☐ 1st trimester ultrasound ☐ 2nd trimester ultrasound ☐ 3rd trimester ultrasound ☐ Other_____		**NAD.7. Maternal age at delivery ____ years**
NAD.8. State/Territory reporting: _____		**NAD.9. County reporting:** _____	
NAD.10. Delivery type: ☐ Vaginal ☐ Caesarean section **NAD.11.** Delivery complication: ☐ No ☐ Yes **NAD.12.** If yes, please describe: _____		**NAD.13. Arterial cord blood pH** (*if performed*): _____ **NAD.14. Venous cord blood pH** (*if performed*): _____	
NAD.15. Placental exam (based on path report): ☐ No ☐ Yes **NAD.16.** If yes, ☐ Normal ☐ Abruption ☐ Inflammation ☐ Other abnormality (*please describe*)			
NAD.17. Apgar score: 1 min _____ / 5 min _____		**NAD.18. Infant temp** (*if abnormal*): _____°F **or** _____°C	
Physical Examination (record earliest measurements taken)			
NAD.19. Birth head circumference: _____☐ cm _____☐ in **NAD.20.** ☐ Molding present **NAD.21.** Physican report: ☐ Normal ☐ Abnormal **NAD.22.** HC percentile:_____		**NAD.23. Birth weight:** _____☐ grams _____☐ lbs/oz **NAD.24.** Birth weight percentile: _____	**NAD.25. Birth length:** _____ ☐ cm _____ ☐ in **NAD.26.** Birth length percentile:_____
NAD.27. *Repeat* head circumference: _____☐ cm _____☐ in **NAD.28.** Date performed ___ /____ /____ *or* Age _____ day(s) **NAD.29.** Physican report: ☐ Normal ☐ Abnormal **NAD.30**. HC percentile:_____		**NAD.31. Admitted to Neonatal Intensive Care Unit:** ☐ No ☐ Yes *If yes*, reason: _____ **NAD.32. Neonatal death:** ☐ No ☐ Yes **NAD.33.** Date __/__/____ *or* Age at death_____ days **NAD.34.** Cause of death: _____	
NAD.35. Microcephaly (head circumference <3%ile): ☐ No ☐ Yes		**NAD.36. Seizures:** ☐ No ☐ Yes	
NAD.37. Neurologic exam: (*check all that apply*) ☐ Not performed ☐ Unknown ☐ Normal ☐ Hypertonia/Spasticity ☐ Hyperreflexia ☐ Irritability ☐ Tremors ☐ Other neurologic abnormalities **NAD.38.** (*please describe below*)			
NAD.39. Splenomegaly *by physical exam*:	**NAD.41. Hepatomegaly** *by physical exam*:		**NAD.43. Skin rash** *by physical exam:*

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☐ No ☐ Yes ☐ Unknown **NAD.40.** (*please describe*)	☐ No ☐ Yes ☐ Unknown **NAD.42.** (*please describe*)	☐ No ☐ Yes ☐ Unknown **NAD.44.** (*please describe*)

NAD.45. Other abnormalities identified: *please check all that apply*

☐ Fetal Brain Disruption Sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)
☐ Encephalocele ☐ Anencephaly/ Acrania ☐ Spina bifida ☐ Holoprosencephaly/arhinencephaly
☐ Microphthalmia/Anophthalmia ☐ Arthrogryposis (congenital joint contractures)
☐ Congenital Talipes Equinovarus (clubfoot) ☐ Congenital hip dislocation/developmental dysplasia of the hip
☐ Other abnormalities
NAD.46. (*please describe below*)

Neonate Imaging and Diagnostics

NAD.47. Hearing screening : *(date:____/_____/_____) or* Age _____ day(s)

NAD.48. ☐ Pass ☐ Fail ☐ Inconclusive/Needs retest ☐ Not performed

NAD.49. Please describe

NAD.50. Audiological evaluation: ☐ Not performed ☐ Auditory brainstem response (ABR) test performed ☐ Otoacoustic emisions (OAE) test performed ☐ Acoustic stapedius reflex (ASR) test performed ☐ Unknown

NAD.51. If performed: Date: ___/___/___ **NAD.52.** ☐ Normal ☐ Abnormal,

NAD.53. Please describe

NAD.54. Retinal exam (with dilation): ☐ Not Performed ☐ Performed ☐ Unknown

NAD.55. *If performed: (date: _____/_____/_____) or* Age _____ day(s)

NAD.56. *please check all that apply:* ☐ Normal

☐ Microphthalmia/Anophthalmia ☐ Coloboma ☐ Cataract ☐ Intraocular calcifications

☐ Chorioretinal atrophy, scarring, macular pallor, gross pigmentary mottling, or retinal hemorrhage, excluding retinopathy of prematurity ☐ Other retinal abnormalities

☐ Optic nerve atrophy, pallor ☐ Other optic nerve abnormalities

NAD.57. (*please describe below)*

NAD.58. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Not Performed

NAD.59. *(date: _____/_____/_____) or* Age _____ day(s)

NAD.60. Findings: *check all that apply* ☐ Normal

☐ Microcephaly ☐ Intracranial calcification ☐ Cerebral / cortical atrophy

☐ Abnormal cortical gyral patterns (lissencephaly, pachygyria, agyria, microgyria, polymicrogyria, schizencephaly)

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☐ Corpus callosum abnormalities ☐ Cerebellar abnormalities ☐ Porencephaly

☐ Hydranencephaly ☐ Moderate or severe ventriculomegaly/hydrocephaly

☐ Fetal Brain Disruption Sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)

☐ Other major brain abnormalities

☐ Encephalocele ☐ Holoprosencephaly/ Arhinencephaly

☐ Other abnormalities

NAD.61. (*please describe below*)

NAD.62. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Not Performed

NAD.63. *(date: _____/_____/_____) or* Age _____ day(s)

NAD.64. Findings: *check all that apply* ☐ Normal

☐ Microcephaly ☐ Intracranial calcification ☐ Cerebral / cortical atrophy

☐ Abnormal cortical gyral patterns (lissencephaly, pachygyria, agyria, microgyria, polymicrogyria, schizencephaly)

☐ Corpus callosum abnormalities ☐ Cerebellar abnormalities ☐ Porencephaly

☐ Hydranencephaly ☐ Moderate or severe ventriculomegaly/hydrocephaly

☐ Fetal Brain Disruption Sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)

☐ Other major brain abnormalities

☐ Encephalocele ☐ Holoprosencephaly/ Arhinencephaly

☐ Other abnormalities

NAD.65. (*please describe below*)

NAD.66. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Not Performed

NAD.67. *(date: _____/_____/_____) or* Age _____ day(s)

NAD.68. Findings: *check all that apply* ☐ Normal

☐ Microcephaly ☐ Intracranial calcification ☐ Cerebral / cortical atrophy

☐ Abnormal cortical gyral patterns (lissencephaly, pachygyria, agyria, microgyria, polymicrogyria, schizencephaly)

☐ Corpus callosum abnormalities ☐ Cerebellar abnormalities ☐ Porencephaly

☐ Hydranencephaly ☐ Moderate or severe ventriculomegaly/hydrocephaly

☐ Fetal Brain Disruption Sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)

☐ Other major brain abnormalities

☐ Encephalocele ☐ Holoprosencephaly/ Arhinencephaly

☐ Other abnormalities

NAD.69. (*please describe below*)

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

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NAD.70. Was a lumbar puncture performed: ☐ Yes ☐ No ☐ Unknown **NAD.71.** *(date:* _____/_____/_____*)* *or* Age _____ day(s)

Postnatal Infection Testing (includes urine culture for CMV)

NAD.72.	Toxoplasmosis infection:	☐ No ☐ Yes ☐ Unknown
NAD.73.	Cytomegalovirus infection:	☐ No ☐ Yes ☐ Unknown
NAD.74.	Herpes Simplex infection:	☐ No ☐ Yes ☐ Unknown
NAD.75.	Rubella infection:	☐ No ☐ Yes ☐ Unknown
NAD.76.	Lymphocytic choriomeningitis virus infection:	☐ No ☐ Yes ☐ Unknown
NAD.77.	Syphilis infection:	☐ No ☐ Yes ☐ Unknown

NAD.78. If yes for any postnatal infection testing, please describe results:

Postnatal (Infant) Cytogenetic Testing

NAD.79. Cytogenetic Test	**NAD.80. Date:**	**NAD.82. Specimen**	**NAD.83. Test Result**
☐ Karyotype ☐ FISH ☐ CGH microarray ☐ Other, specify _____	_____/_____/_____ **NAD.81. Infant Age: _____ months**	☐ Cord blood ☐ Peripheral blood ☐ Tissue ☐ Other, specify _____	☐ Normal ☐ Abnormal ☐ Unknown

NAD.84. Description of cytogenetic test findings (verbatim):

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

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NAD.85. Other tests/results/diagnosis (*include dates*):

Birth Defects Diagnosed or Suspected (Include Chromosomal Abnormalities and Syndromes)

Diagnostic Code	Certainty	Verbatim Description
	☐Definite ☐Possible/Probable	
	☐Definite ☐Possible/Probable	
	☐Definite ☐Possible/Probable	
	☐Definite ☐Possible/Probable	
	☐Definite ☐Possible/Probable	
	☐Definite ☐Possible/Probable	

Health Department Information

NAD.86. Name of person completing form: _____

NAD.87. Phone: _____

NAD.88. Email: _____ NAD.89. Date of form completion_____/_____/____

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