

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

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



U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Infant Follow-Up 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 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**

Infant follow up: <input type="checkbox"/> 2 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> ___ months			
IFU.1. State/Territory reporting _____		IFU.2. Date of infant examination ____/____/____	
IFU.3. Infant's State/Territory ID _____	IFU.4. Mother's State/Territory ID _____	IFU.5. DOB: ____/____/____	IFU.6. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous/undetermined
IFU.7. Infant Death: <input type="checkbox"/> No <input type="checkbox"/> Yes			
IFU.8. If yes, cause of death _____			
IFU.9. If yes, Date ____/____/____ or Age at death _____ <input type="checkbox"/> Unknown			
IFU.10. Weight: _____ grams or ___ lbs ___ oz		IFU.11. Length: _____ cm or _____ in	
IFU.12. Head circumference: _____ cm or _____ in			
IFU.13. Infant findings for corrected age at examination: <i>(For infants born preterm, please account for corrected age: chronological age minus weeks born before 40 weeks' gestation)</i> Check all that apply			
<input type="checkbox"/> Normal <input type="checkbox"/> Microcephaly (head circumference <3%ile)			
<input type="checkbox"/> Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)			
<input type="checkbox"/> Anencephaly/ acrania <input type="checkbox"/> Encephalocele <input type="checkbox"/> Spina bifida			
<input type="checkbox"/> Holoprosencephaly/arhinencephaly <input type="checkbox"/> Microphthalmia/Anophthalmia			
<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"/> Swallowing/feeding difficulties			
<input type="checkbox"/> Arthrogryposis (congenital joint contractures)			
<input type="checkbox"/> Congenital talipes equinovarus (clubfoot)			
<input type="checkbox"/> Congenital hip dislocation/developmental dysplasia of the hip			
<input type="checkbox"/> Other abnormalities			
IFU.14. Please list other abnormal findings: 			
IFU.15. Development assessment for corrected age at examination: <i>(For infants born preterm, please account for corrected age: chronological age minus weeks born before 40 weeks' gestation)</i> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown			
IFU.16. 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			
Special Studies Since Last Follow-up			
IFU.17. Imaging study: <input type="checkbox"/> Cranial ultrasound <input type="checkbox"/> MRI <input type="checkbox"/> CT <input type="checkbox"/> Other _____			

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Not Performed Unknown

IFU.18. Date: ____/____/____

IFU.19. Findings: *check all that apply* Normal

- Microcephaly Intracranial calcifications 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

IFU.20. *Please describe below*

IFU.21. Imaging study: Cranial ultrasound MRI CT Other _____

Not Performed Unknown

IFU.22. Date: ____/____/____

IFU.23. Findings: *check all that apply* Normal

- Microcephaly Intracranial calcifications 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

IFU.24. *(please describe below)*

IFU.25. Hearing screening or re-screening: Not performed Performed Unknown

IFU.26. *If performed:* Date: ____/____/____ **IFU.27.** Pass Fail or referred,

IFU.28. *Please describe*

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IFU.29. Audiological evaluation: Not performed Performed Unknown

IFU.30. *If performed:* Date: ____/____/____ **IFU.31.** Normal Abnormal,

IFU.32. *Please describe*

IFU.33. Retinal exam (with dilation): Not Performed Performed Unknown

IFU.34. *If performed:* Date: ____/____/____

IFU.35. Findings: *Check all that apply:*

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

IFU.36. *Please describe*

IFU.37. Other abnormal tests/results/diagnosis (include dates): No Yes

IFU.38. Date: ____/____/____

IFU.39. *Please describe*

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Health Department Information

IFU.40. Name of person completing form: _____

IFU.41. Phone: _____ IFU.40. Email: _____

IFU.42. Date of form completion ____/____/____

Internal use only

Date entered ____/____/____

Data Entry Notes:

Data Entry POC Initials: _____

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)