**ZIKV RNA Persistence (ZIRP): Infant Baseline and Delivery Questionnaire**

TO BE COMPLETED THROUGH MEDICAL RECORD ABSTRACTION

**PART I: Enrollment**

|  |  |
| --- | --- |
| *Clinic Information* | *Infant Information* |
| Clinic name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | Last name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Municipality\*: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | First name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Study site # (if applicable): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |

1. Did the infant’s parent(s) sign informed consent for participation? □1Yes □0 No

*If yes,* date when informed consent was signed (mm/dd/yyyy): **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*If no,* reason: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. What is the mother’s study identifier number? \_\_\_- \_\_\_ \_\_\_ \_\_\_ - 0
2. What date was the mother enrolled (mm/dd/yyyy)? \_\_\_\_\_\_\_\_\_\_\_\_
3. What is the infant’s study identifier number? \_\_\_ - \_\_\_ \_\_\_ \_\_\_- \_\_\_ (corresponding infant number: 1 for first, 2 for second)

**PART II: Delivery**

5. Infant’s birthdate? \_\_ \_\_/\_\_ \_\_ /\_\_ \_\_ \_\_ \_\_ 🞎77 *Don’t know*

M M D D Y Y Y Y

6. Gestational age at time of birth? \_\_\_\_\_\_\_\_ weeks \_\_\_\_\_\_ days

7. What was the basis of the gestational age at birth?

🞎1 Last menstrual period

🞎2 Ultrasound

🞎3 Assisted reproduction

🞎4 Other

8. Infant’s sex? 🞎1 Male 🞎0 Female

9. Infant’s birth weight (<12 hours after delivery)? \_\_\_\_\_\_\_\_🞎 grams 🞎kilograms 🞎 pounds 🞎77 *Don’t know*

10. Infant’s crown-to-heel length? \_\_\_\_\_\_\_\_🞎 inches 🞎 centimeters 🞎77 *Don’t know*

11. Infant’s head circumference (Occipito-frontal after 24h following birth)? \_\_\_\_\_\_\_\_ centimeters 🞎77 *Don’t know*

12. Infant’s APGAR score?

1 minutes after birth\_\_\_\_\_\_\_\_, 🞎77 *Don’t know*

5 minutes after birth\_\_\_\_\_\_\_\_, 🞎77 *Don’t know*

10 minutes after birth\_\_\_\_\_\_\_\_, 🞎77 *Don’t know*

13. Infant’s maximum temperature at birth: °C or °F

🞎1 Oral 🞎2 Tympanic 🞎3Rectal 🞎4 Axillary

14. How was the infant delivered? (tick one box)

🞎1 Vaginal spontaneous

🞎2 Vaginal assisted (eg. forceps, vaccuum)

🞎3 Caesarian section

🞎4 Assisted Breach

🞎77 Don’t know

15. What was the fetal presentation of the infant at delivery? (tick one box)

🞎1 Cephalic

🞎2 Breech

🞎3 Other

16. Where was the infant delivered? (tick one box)

🞎1 Home

🞎2 Health facility

🞎77 Don’t know

17. Were there intra-partum complications? 🞎1 Yes 🞎0 No 🞎77 *Don’t know*

18. Were there post-partum complications? 🞎1 Yes 🞎0 No 🞎77 *Don’t know*

19. Please indicate the infant has had of any of the following conditions by marking “yes”, “no” or ”I don’t know”. If you mark yes in any of the conditions please fill out the fourth column to the right of each individual condition.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | I don’t know | **If yes……,** |
| Seizures |  |  |  | 🞎1 General  🞎2 Focal |
| Paralysis |  |  |  | 🞎1 General  🞎2 Ascending |
| Increased stiffness in limbs |  |  |  | Describe: \_\_\_\_\_\_\_ |
| Floppiness (hypotonia) |  |  |  | Describe: \_\_\_\_\_\_\_ |
| Joint contractures |  |  |  | Describe: \_\_\_\_\_\_\_ |
| Other neurological signs |  |  |  | Describe: \_\_\_\_\_\_\_ |
| Oedema |  |  |  | Describe: \_\_\_\_\_\_\_ |
| Apnea |  |  |  | Describe: \_\_\_\_\_\_\_ |
| Rash |  |  |  | Type of rash: \_\_\_\_\_\_\_  Date of rash onset (mm/dd/yyyy): \_\_\_\_\_\_\_ |
| Other abnormal skin condition |  |  |  | Type:  Date of onset (mm/dd/yyyy): \_\_\_\_\_\_\_ |

20.Please indicate if any of the following birth abnormalities were present ≤ 24 post-delivery by marking “yes”, “no” or ”I don’t know” for each one.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | I don’t know |
| Facial Dysmorphia |  |  |  |
| Cleft lip/palate |  |  |  |
| Eye abnormalities |  |  |  |
| Ear abnormalities |  |  |  |
| Excess head skin |  |  |  |
| Small skull (Craniosynostosis) |  |  |  |
| Down syndrome features |  |  |  |
| Enlarged back of the head |  |  |  |
| Congenital heart defects |  |  |  |
| Lump under the skin (Haemangionmas) |  |  |  |
| Umbilical hernia |  |  |  |
| Abdominal wall defect |  |  |  |

21. Please indicate if any of the following birth abnormalities were present ≤ 24 post-delivery by marking “yes”, “no” or ”I don’t know” for each one. If you mark yes in any of the conditions please fill out the fourth column to the right of each individual condition.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | I don’t know | If yes, |
| Hand abnormalities |  |  |  | ☐1Missing fingers  ☐2Curving of the little finger towards ring finger  ☐3Other |
| Foot abnormalities |  |  |  | ☐1Wide spaced toes  ☐2Clubfoot  ☐3Other |
| Upper limb abnormalities |  |  |  | Describe: \_\_\_\_\_\_\_\_\_\_\_ |
| Lower limb abnormalities |  |  |  | Describe: \_\_\_\_\_\_\_\_\_\_\_ |

22. Was imaging performed on the infant within 24 hours after birth? 🞎1 Yes 🞎0 No 🞎77 *Don’t know*

*If yes,* what type? (tick box)

🞎1 Cranial ultrasound scan

Result: 🞎1 Normal 🞎2 Abnormal

🞎2 CT scan

Result: 🞎1 Normal 🞎2 Abnormal

🞎3 MRI

Result: 🞎1 Normal 🞎2 Abnormal

🞎4 Other

Result: 🞎1 Normal 🞎2 Abnormal

**PART III: Microbiology testing**

23. Was a blood specimen taken? 🞎1 Yes 🞎0 No

23a. *If no,* why?

🞎0 The last two study related blood draws came out negative for Zika virus infection

🞎1 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

23b. *If yes,*

23.b.1. Date of specimen collection (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_

23.b.2 Time of specimen collection (hh:mm): \_\_\_\_\_\_\_\_\_\_\_\_

23.b.3. Date specimen was sent to laboratory (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_

23.b.4. Type of test:

🞎0 RT-PCR

🞎1. IgM

🞎2. RT-PCR & IgM

🞎3 Other

24. Was a urine sample taken? 🞎1 Yes 🞎0 No

24a. *If no,* why?

🞎0 The last two study related urine samples came out negative for Zika virus infection

🞎1 Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24.b. *If yes,*

24.b.1. Date of specimen collection (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_

24.b.2 Time of specimen collection (hh:mm): \_\_\_\_\_\_\_\_\_\_\_\_

24.b.3. Date specimen was sent to laboratory (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_

24.b.4. Type of test:

🞎0 RT-PCR

🞎1. IgM

🞎2. RT-PCR & IgM

🞎3 Other

25. Was a cerebrospinal fluid (CSF) sample taken from the infant after birth? 🞎1 Yes 🞎0 No 🞎77 *Don’t know*

*If yes,* Date (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_

*If yes,* Fluid appearance: 🞎1 Clear and colourless 🞎2 Cloudy 🞎3 Blood stained 🞎4 Unknown

26. Was a pediatrician identified for the follow-up of the infant? 🞎1 Yes 🞎0 No

If no, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE: A PEDIATRICIAN MUST BE IDENTIFIED BY THE STUDY STAFF PRIOR TO THE INFANTS DEPARTURE FROM THE DELIVERY HOSPITAL/CLINIC**