Form Approved
OMB Control No.: 0920-XXXX
Expiration date: XX/XX/XXXX

Site code	Participant code	Infant Number
I__I	I___I___I___I	I__I

Name of Person Completing the Form: _____

Today's date: _____/_____/_____
MM DD YYYY

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

TO BE COMPLETED THROUGH MEDICAL RECORD ABSTRACTION

PART I: Enrollment

Clinic Information

Clinic name: _____

Municipality*: _____

Study site # (if applicable): _____

Infant Information

Last name: _____

First name: _____

1. Did the infant's parent(s) sign informed consent for participation? ☐$_1$Yes ☐$_0$ No
   If yes, date when informed consent was signed (mm/dd/yyyy): _____

   If no, reason: _____
2. What is the mother's study identifier number? ___- ___ ___ ___ - 0
3. What date was the mother enrolled (mm/dd/yyyy)? _____
4. 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*

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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 ☐$_3$Rectal ☐$_4$ Axillary

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

☐$_1$ Vaginal spontaneous

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☐$_2$ 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: _____

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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				☐$_1$Missing fingers

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				☐$_2$Curving of the little finger towards ring finger ☐$_3$Other
Foot abnormalities				☐$_1$Wide spaced toes ☐$_2$Clubfoot ☐$_3$Other
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?

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☐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

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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