Att. C 5

Form Approved
OMB No. 0920-XXXX
Exp. Date XX/XX/20XX

Site code	Participant code	Pregnant Woman
I_I	I___I___I___I	I__I

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

Public reporting burden of this collection of information is estimated to average 8 minutes, 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 D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1189).

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

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

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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): ________

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

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 ☐$_2$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

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Today's date: _____/______/________
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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,*

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MM DD YYYY

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