Att. C 6

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 Follow-up Questionnaire

1. Study visit #:____________

2. Study visit location:

   ☐1 Pediatrician's office
   ☐2 Other, specify: ____

3. Date of last study visit (mm/dd/yyyy): ____________

4. Have the infant's last two study related blood draws come out negative for Zika virus infection by rRT-PCR? ☐1 Yes ☐0 No

TO BE COMPLETED BY INFANT'S PARENT/GUARDIAN

PART I: General Health

Thank you for allowing your infant to participate in this study. We will now like to ask you questions about your infant's general health since his last study visit. Since your infant's last study visit (or delivery if this is his first visit)…

5. Have you had any concerns about the health of your infant? ☐1 Yes ☐0 No
   i. If yes, please specify your concerns____________

6. Has your infant visited the emergency room since his/her last visit? ☐1 Yes ☐0 No
   ii. If yes, reason of visit____________ Name of facility____________

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

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

7. Has your infant been hospitalized since his/her last visit? ☐$_1$ Yes ☐$_0$ No
   iii. If yes, reason of hospitalization_____________ Name of facility_____________

8. Has your infant had an outpatient visit not requiring an ER visit or hospitalization? ☐$_1$ Yes ☐$_0$ No
   If yes, reason of visit_____________ Name of facility_____________

9. Has your infant had blood taken since his/her last visit? ☐$_1$ Yes ☐$_0$ No
   iv. If yes, reason of blood collection_____________

10. Has your infant given a urine sample since his/her last visit? ☐$_1$ Yes ☐$_0$ No
   v. If yes, reason of urine collection_____________

TO BE COMPLETED BY MEDICAL RECORD ABSTRACTION

PART I: Vitals

11. Infant's weight? _________ ☐ grams ☐ kilograms
12. Infant's height? _________☐ centimeters ☐ inches
13. Infant's head circumference? _________centimeters

PART II: Neurological development

14. Has the baby experienced any of the following since his/her last visit?
   vi. Apnea ☐$_1$ Yes ☐$_0$ No ☐$_{77}$ Unknown
   vii. Seizures ☐$_1$ Yes ☐$_0$ No ☐$_{77}$ Unknown
   viii. Paralysis ☐$_1$ Yes ☐$_0$ No ☐$_{77}$ Unknown
   ix. Joint Contracture ☐$_1$ Yes ☐$_0$ No ☐$_{77}$ Unknown
   x. Floppiness ☐$_1$ Yes ☐$_0$ No ☐$_{77}$ Unknown
   xi. Other: ☐$_1$ Yes ☐$_0$ No ☐$_{77}$ Unknown
   If yes, Specify: _____________

15. Signs of any of the following abnormalities in the infant since his/her last visit?
   xii. Facial dysmorphia ☐$_1$ Yes ☐$_0$ No ☐$_{77}$ Unknown
   xiii. Eye abnormalities ☐$_1$ Yes ☐$_0$ No ☐$_{77}$ Unknown
   xiv. Ear abnormalities ☐$_1$ Yes ☐$_0$ No ☐$_{77}$ Unknown
   xv. Excess head skin ☐$_1$ Yes ☐$_0$ No ☐$_{77}$ Unknown
   xvi. Reduced size of the skull ☐$_1$ Yes ☐$_0$ No ☐$_{77}$ Unknown
   xvii. Down syndrome features ☐$_1$ Yes ☐$_0$ No ☐$_{77}$ Unknown
   xviii. Other: ☐$_1$ Yes ☐$_0$ No ☐$_{77}$ Unknown
   If yes, Specify: _____________

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MM DD YYYY

PART III: Microbiology testing

16. Was a blood specimen of the infant taken? ☐$_1$ Yes ☐$_0$ No

16a. *If no,* why?

☐$_0$ The last two study related blood draws came out negative for Zika virus infection
☐$_1$ Other, specify ______________________________________

16b. Date (mm/dd/yyyy)
16c. Time (hh:mm) of specimen collection: ____________
16d. Date specimen was sent to laboratory (mm/dd/yyyy): ____________

16e. Type of test:

☐$_0$ RT-PCR
☐$_{1.}$ IgM
☐$_2$ RT-PCR & IgM
☐$_3$ Other

17. Was a urine sample of the baby obtained? ☐$_1$ Yes ☐$_0$ No

17a. *If no,* why?

☐$_0$ The last two study related urine samples came out negative for Zika virus infection
☐$_1$ Other, specify ______________________________________

17b. Date (mm/dd/yyyy)
17c. Time (hh:mm) of specimen collection: ____________
17d. Date specimen was sent to laboratory (mm/dd/yyyy): ____________

17e. Type of test:

☐$_0$ RT-PCR
☐$_{1.}$ IgM
☐$_2$ RT-PCR & IgM
☐$_3$ Other

PART IV: Study Termination

18. Was data collection concluded for this infant for the study? ☐$_1$ Yes ☐$_0$ No

18a$_1$. If yes, reason:

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I___I	I___I___I___I	I__I

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

☐0 Last two sample collections tested negative for Zika confirmed by RT-PCR
☐1 End of study period
☐2 Admitted to hospital for adverse outcomes
☐3 Withdrawn from study by guardian
☐4 Terminated by study staff
☐5 Other, specify ____________________________________

18a2. If yes, date of study termination (mm/dd/yyyy): ____________