



## Pregnancy and Zika virus disease surveillance 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 by sending an encrypted email to [ZIKApregnancy@cdc.gov](mailto:ZIKApregnancy@cdc.gov) or by fax to the secure number: 404-718-2200. Pregnancy & Birth Defects phone number: 770-488-7100

Neonate Assessment			
Infant's name: _____ Last First MI			Birth Certificate ID: _____
Infant's State/Territory ID _____	Mother's State/Territory ID _____	DOB: ____/____/____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous/undetermined
Gestational age at delivery: ____ weeks ____ days		Based on: (check all that apply) <input type="checkbox"/> LMP ____/____/____ <input type="checkbox"/> U/S (1 <sup>st</sup> trimester) <input type="checkbox"/> U/S (2 <sup>nd</sup> trimester) <input type="checkbox"/> U/S (3 <sup>rd</sup> trimester) <input type="checkbox"/> Other _____	
State/Territory of residence: _____		County of residence: _____	
Delivery type: <input type="checkbox"/> Vaginal <input type="checkbox"/> Caesarean section Delivery complication: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, _____		Arterial Cord blood pH: if performed _____ Venous Cord blood pH: if performed _____	
Placental exam (based on path report): <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, <input type="checkbox"/> Normal <input type="checkbox"/> Abruptio <input type="checkbox"/> Inflammation <input type="checkbox"/> Other abnormality (please describe)			
Apgar score: 1 min ____ / 5 min ____		Infant temp (if abnormal): ____ °F	
Physical Examination			
Birth head circumference: ____ <input type="checkbox"/> cm ____ <input type="checkbox"/> in <input type="checkbox"/> molding present Physican report: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Birth weight: ____ <input type="checkbox"/> grams ____ <input type="checkbox"/> lbs/oz	Birth length: ____ <input type="checkbox"/> cm ____ <input type="checkbox"/> in
Repeat head circumference: ____ <input type="checkbox"/> cm ____ <input type="checkbox"/> in <input type="checkbox"/> < 24hrs <input type="checkbox"/> 24-35hrs <input type="checkbox"/> 36-48hrs <input type="checkbox"/> > 48hrs Physican report: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Admitted to Neonatal Intensive Care Unit: <input type="checkbox"/> No <input type="checkbox"/> Yes, If yes, reason _____	
Microcephaly (head circumference <3%ile): <input type="checkbox"/> No <input type="checkbox"/> Yes		Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Neurologic exam: check all that apply <input type="checkbox"/> Not performed <input type="checkbox"/> Unknown <input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia/Spasticity <input type="checkbox"/> Hyperreflexia <input type="checkbox"/> Irritability <input type="checkbox"/> Tremors <input type="checkbox"/> Other Neurologic abnormalities (please describe below)			
Splenomegaly by physical exam: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown (please describe)	Hepatomegaly by physical exam: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown (please describe)	Skin rash by physical exam: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown (please describe)	
Other abnormalities identified: (please provide clinical description from medical records and include chromosomal abnormalities and syndromes); please check all that apply			

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<input type="checkbox"/> Microphthalmia Arthrogyposis (congenital joint contractures) <input type="checkbox"/> Other abnormalities ( <i>please describe below</i> )	<input type="checkbox"/> Absent red reflex <input type="checkbox"/> Excessive and redundant scalp skin <input type="checkbox"/> Congenital Talipes Equinovarus (clubfoot)
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### Neonate Imaging and Diagnostics

**Hearing screening :** (date: \_\_\_/\_\_\_/\_\_\_)  Pass  Fail or referred  Not performed  
 (*please describe below*)

**Retinal exam (with dilation):**  Not Performed  Unknown  
 If performed: (date: \_\_\_/\_\_\_/\_\_\_) *please check all that apply:*  
 Microphthalmia  Chorioretinitis  Macular pallor  Other retinal abnormalities (*please describe below*)

**Imaging study:**  Cranial ultrasound (date: \_\_\_/\_\_\_/\_\_\_)  MRI (date: \_\_\_/\_\_\_/\_\_\_)  
 CT (date: \_\_\_/\_\_\_/\_\_\_)  Not Performed

**Findings: check all that apply**

<input type="checkbox"/> Microcephaly	<input type="checkbox"/> Cerebral (brain) atrophy	<input type="checkbox"/> Intracranial calcification	<input type="checkbox"/> Ventricular enlargement
<input type="checkbox"/> Lissencephaly	<input type="checkbox"/> Pachygyria	<input type="checkbox"/> Hydranencephaly	<input type="checkbox"/> Porencephaly
<input type="checkbox"/> Abnormality of corpus callosum	<input type="checkbox"/> Other abnormalities ( <i>please describe below</i> )		

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Lissencephaly     Pachygyria     Hydranencephaly     Porencephaly  
 Abnormality of corpus callosum  
 Other abnormalities (*please describe below*)

**Was a lumbar puncture performed:**  Yes  No  Unknown (*date: \_\_\_/\_\_\_/\_\_\_*)

**Congenital Infection Testing:** *if performed, please specify test (i.e. PCR, IgG, IgM)*

	Toxoplasmosis	Cytomegalovirus	Herpes Simplex	Rubella	Other
Positive					
Negative					
Not Done					
Date					

**Other tests/results/diagnosis (include dates):**

### Provider Information

**Neonatal Provider name:**  Dr.  PA  RN  Mr.  Ms. \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_ **Date of form completion** \_\_\_/\_\_\_/\_\_\_

**Pediatric Provider name:**  Dr.  PA  RN  Mr.  Ms. \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Name of person completing form: (if different from provider)** \_\_\_\_\_

**Hospital/facility:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Name of Infant Pediatrician:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_ **Date of form completion** \_\_\_/\_\_\_/\_\_\_

### Health Department Information

**Name of person completing form:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_ **Date of form completion** \_\_\_/\_\_\_/\_\_\_

**FOR INTERNAL CDC USE ONLY**

**Mother ID:** \_\_\_\_\_ **State/territory ID:** \_\_\_\_\_

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)