THE U.S. ZIKA PREGNANCY REGISTRY
DATA SUBMISSION PROCESS
Neonate Assessment Form

The California Department of Public Health (CDPH) is participating in the U.S. Zika Pregnancy Registry and is the point of contact for California data submission to the Centers for Disease Control and Prevention (CDC).

Who Is Eligible for the Registry?

- Pregnant women in the United States with laboratory evidence of Zika virus infection (positive or equivocal test results, regardless of whether they have symptoms) and periconceptionally, prenatally, or perinatally exposed infants born to these women.
- Infants with laboratory evidence of congenital Zika virus infection (positive or equivocal test results, regardless of whether they have symptoms) and their mothers.

To participate, follow the directions below:

Healthcare Provider Instructions	Local Health Department Instructions
▪ Healthcare providers should contact their Local Health Department (LHD) for questions about data submission. ▪ Providers may be contacted by either the LHD or CDPH for Zika pregnancy and infant outcomes data collection. ▪ Click here for more information on reporting Zika pregnancy and infant outcomes to CDPH.	▪ Local Health Departments may choose to follow up with healthcare providers or ask CDPH staff to follow-up. LHDs should inform CDPH of the LHD preference at: ZikaOutcomes@cdph.ca.gov. ▪ Various methods (e.g., medical record abstraction, telephone interview) can be used to collect surveillance information for the Registry. ▪ LHDs contacting providers to complete the attached form should insert the LHD contact information below for provider submission. ▪ LHDs should ensure completion of the attached form and then submit to CPDH by e-mail or fax as instructed below.

FORM PROCESSING INSTRUCTIONS

Send this form to:

☐ **California Department of Public Health**
Fax: (510) 620-3152
Phone: (510) 620-3151
Email: ZikaOutcomes@cdph.ca.gov (Please send a message for instructions **before** submission).

☑ **My Local Health Department at the address below:**
Los Angeles County Department of Public Health
Children's Medical Services Division
Phone: (626) 569-6508 Fax: (626) 569-1909

Security note:
-Call prior to faxing forms to CDPH or Local Health Department.
*-Please **DO NOT** scan and email documents before receiving instructions.*

HIPAA Privacy Rule permits providers to disclose PHI without authorization to public health authorities for the purposes of preventing or controlling disease.
The CDPH California Birth Defects Monitoring Program (CBDMP) is authorized to conduct studies to investigate the causes of birth defects (H&S section 103840).

California Department of PublicHealth

Reset Form

U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Neonate Assessment Form

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Please return completed form via SAMS or secure FTP—request access from ZIKApregnancy@cdc.gov
The form can also be sent by encrypted email to this address or by secure fax to 404-718-1013 or 404-718-2200
Contact Pregnancy & Birth Defects Task Force phone number: 770-488-7100

NAD.1. Infant's State/Territory ID _____	**NAD.2. Mother's State/Territory ID** _____	**NAD.3. DOB:** _____ ☐ Live birth ☐ Stillbirth ≥20 weeks	**NAD.4. Sex:** ☐ Male ☐ Female ☐ Ambiguous/undetermined
NAD.5. Gestational age at delivery: _____ weeks _____ days	**NAD.6. Based on**: (*check all that apply*) ☐ LMP Date:_____ ☐ 1st trimester ultrasound ☐ 2nd trimester ultrasound ☐ 3rd trimester ultrasound ☐ Other_____		**NAD.7. Maternal age at delivery** ____ years
NAD.8. State/Territory reporting: Select State		**NAD.9. County reporting:** _____	
NAD.10. Delivery type: ☐ Vaginal ☐ Caesarean section **NAD.11.** Delivery complication: ☐ No ☐ Yes **NAD.12.** If yes, please describe: _____		**NAD.13. Arterial cord blood pH** (*if performed*): _____ **NAD.14. Venous cord blood pH** (*if performed*): _____	
NAD.15. Placental exam (based on path report): ☐ No ☐ Yes **NAD.16.** If yes, ☐ Normal ☐ Abruption ☐ Inflammation ☐ Other abnormality (*please describe*)			
NAD.17. Apgar score: 1 min _____ / 5 min _____		**NAD.18. Infant temp** (*if abnormal*): _____ °F **or** _____ °C	
Physical Examination (record earliest measurements taken)			
NAD.19. Birth head circumference: _____☐ cm _____☐ in **NAD.20.** ☐ Molding present **NAD.21.** Physican report: ☐ Normal ☐ Abnormal **NAD.22.** HC percentile:_____		**NAD.23. Birth weight:** _____☐ grams _____☐ lbs/oz **NAD.24.** Birth weight percentile: _____	**NAD.25. Birth length:** _____ ☐ cm _____ ☐ in **NAD.26.** Birth length percentile:_____
NAD.27. *Repeat* head circumference: _____☐ cm _____☐ in **NAD.28.** Date performed: _____ *or* Age _____ day(s) **NAD.29.** Physican report: ☐ Normal ☐ Abnormal **NAD.30**. HC percentile:_____		**NAD.31. Admitted to Neonatal Intensive Care Unit:** ☐ No ☐ Yes *If yes,* reason: _____ **NAD.32. Neonatal death:** ☐ No ☐ Yes **NAD.33.** Date: _____ *or* Age at death_____ days **NAD.34.** Cause of death: _____	
NAD.35. Microcephaly (head circumference <3%ile): ☐ No ☐ Yes		**NAD.36. Seizures:** ☐ No ☐ Yes	
NAD.37. Neurologic exam: (*check all that apply*) ☐ Not performed ☐ Unknown ☐ Normal ☐ Hypertonia/Spasticity ☐ Hyperreflexia ☐ Irritability ☐ Tremors ☐ Other neurologic abnormalities **NAD.38.** (*please describe below*)			

Infant's State/Territory ID_____ Mother's State/Territory ID _____

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NAD.39. Splenomegaly *by physical exam*: ☐ No ☐ Yes ☐ Unknown **NAD.40.** (*please describe*)	**NAD.41. Hepatomegaly** *by physical exam*: ☐ No ☐ Yes ☐ Unknown **NAD.42.** (*please describe*)	**NAD.43. Skin rash** *by physical exam:* ☐ No ☐ Yes ☐ Unknown **NAD.44.** (*please describe*)

NAD.45. Other abnormalities identified: *please check all that apply*

☐ Fetal Brain Disruption Sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)
☐ Encephalocele ☐ Anencephaly/ Acrania ☐ Spina bifida ☐ Holoprosencephaly/arhinencephaly
☐ Microphthalmia/Anophthalmia ☐ Arthrogryposis (congenital joint contractures)
☐ Congenital Talipes Equinovarus (clubfoot) ☐ Congenital hip dislocation/developmental dysplasia of the hip
☐ Other abnormalities

NAD.46. (*please describe below*)

Neonate Imaging and Diagnostics

NAD.47. Hearing screening : (Date:_____) *or* Age _____ day(s)

NAD.48. ☐ Pass ☐ Fail ☐ Inconclusive/Needs retest ☐ Not performed

NAD.49. Please describe

NAD.50. Audiological evaluation: ☐ Not performed ☐ Auditory brainstem response (ABR) test performed ☐ Otoacoustic emisions (OAE) test performed ☐ Acoustic stapedius reflex (ASR) test performed ☐ Unknown

NAD.51. If performed: Date: _____ **NAD.52.** ☐ Normal ☐ Abnormal

NAD.53. Please describe

NAD.54. Retinal exam (with dilation): ☐ Not Performed ☐ Performed ☐ Unknown

NAD.55. *If performed:* (Date: _____) *or* Age _____ day(s)

NAD.56. *please check all that apply:* ☐ Normal

☐ Microphthalmia/Anophthalmia ☐ Coloboma ☐ Cataract ☐ Intraocular calcifications

☐ Chorioretinal atrophy, scarring, macular pallor, gross pigmentary mottling, or retinal hemorrhage, excluding retinopathy of prematurity ☐ Other retinal abnormalities

☐ Optic nerve atrophy, pallor ☐ Other optic nerve abnormalities

NAD.57. (*please describe below)*

NAD.58. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Not Performed

NAD.59. (Date: _____) *or* Age _____ day(s)

NAD.60. Findings: *check all that apply* ☐ Normal

☐ Microcephaly ☐ Intracranial calcification ☐ Cerebral / cortical atrophy

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☐ Abnormal cortical gyral patterns (lissencephaly, pachygyria, agyria, microgyria, polymicrogyria, schizencephaly)

☐ Corpus callosum abnormalities ☐ Cerebellar abnormalities ☐ Porencephaly

☐ Hydranencephaly ☐ Moderate or severe ventriculomegaly/hydrocephaly

☐ Fetal Brain Disruption Sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)

☐ Other major brain abnormalities

☐ Encephalocele ☐ Holoprosencephaly/ Arhinencephaly

☐ Other abnormalities

NAD.61. (*please describe below*)

NAD.62. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Not Performed

NAD.63. (Date: _____) *or* Age _____ day(s)

NAD.64. Findings: *check all that apply* ☐ Normal

☐ Microcephaly ☐ Intracranial calcification ☐ Cerebral / cortical atrophy

☐ Abnormal cortical gyral patterns (lissencephaly, pachygyria, agyria, microgyria, polymicrogyria, schizencephaly)

☐ Corpus callosum abnormalities ☐ Cerebellar abnormalities ☐ Porencephaly

☐ Hydranencephaly ☐ Moderate or severe ventriculomegaly/hydrocephaly

☐ Fetal Brain Disruption Sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)

☐ Other major brain abnormalities

☐ Encephalocele ☐ Holoprosencephaly/ Arhinencephaly

☐ Other abnormalities

NAD.65. (*please describe below*)

NAD.66. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Not Performed

NAD.67. (Date: _____) *or* Age _____ day(s)

NAD.68. Findings: *check all that apply* ☐ Normal

☐ Microcephaly ☐ Intracranial calcification ☐ Cerebral / cortical atrophy

☐ Abnormal cortical gyral patterns (lissencephaly, pachygyria, agyria, microgyria, polymicrogyria, schizencephaly)

☐ Corpus callosum abnormalities ☐ Cerebellar abnormalities ☐ Porencephaly

☐ Hydranencephaly ☐ Moderate or severe ventriculomegaly/hydrocephaly

☐ Fetal Brain Disruption Sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)

☐ Other major brain abnormalities

☐ Encephalocele ☐ Holoprosencephaly/ Arhinencephaly

Infant's State/Territory ID_____ Mother's State/Territory ID _____

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☐ Other abnormalities

NAD.69. (*please describe below*)

NAD.70. Was a lumbar puncture performed: ☐ Yes ☐ No ☐ Unknown **NAD.71.** (Date: _____)
or Age _____ day(s)

Postnatal Infection Testing (includes urine culture for CMV)		
NAD.72.	Toxoplasmosis infection:	☐ No ☐ Yes ☐ Unknown
NAD.73.	Cytomegalovirus infection:	☐ No ☐ Yes ☐ Unknown
NAD.74.	Herpes Simplex infection:	☐ No ☐ Yes ☐ Unknown
NAD.75.	Rubella infection:	☐ No ☐ Yes ☐ Unknown
NAD.76.	Lymphocytic choriomeningitis virus infection:	☐ No ☐ Yes ☐ Unknown
NAD.77.	Syphilis infection:	☐ No ☐ Yes ☐ Unknown

NAD.78. If yes for any postnatal infection testing, please describe results:

Postnatal (Infant) Cytogenetic Testing

NAD.79. Cytogenetic Test	**NAD.80. Date:**	**NAD.82. Specimen**	**NAD.83. Test Result**
☐ Karyotype ☐ FISH ☐ CGH microarray ☐ Other, specify _____	_____ **NAD.81. Infant Age:** _____ **months**	☐ Cord blood ☐ Peripheral blood ☐ Tissue ☐ Other, specify _____	☐ Normal ☐ Abnormal ☐ Unknown

NAD.84. Description of cytogenetic test findings (verbatim):

Infant's State/Territory ID_____ Mother's State/Territory ID _____

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NAD.85. Other tests/results/diagnosis (*include dates*):

Birth Defects Diagnosed or Suspected (Include Chromosomal Abnormalities and Syndromes)

Diagnostic Code	Certainty	Verbatim Description
	☐ Definite ☐ Possible/Probable	
	☐ Definite ☐ Possible/Probable	
	☐ Definite ☐ Possible/Probable	
	☐ Definite ☐ Possible/Probable	
	☐ Definite ☐ Possible/Probable	
	☐ Definite ☐ Possible/Probable	

Health Department Information

NAD.86. Name of person completing form: _____

NAD.87. Phone: _____

NAD.88. Email: _____ NAD.89. Date of form completion_____

FOR INTERNAL CDC USE ONLY

Mother ID: **State/territory ID:**