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 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: ☐ Male ☐ Female ☐ Ambiguous/undetermined

Gestational age at delivery: _____ weeks _____ days

Based on: (*check all that apply*) ☐ LMP ___/___/___ ☐ U/S (1st trimester) ☐ U/S (2nd trimester) ☐ U/S (3rd trimester) ☐ Other_____

State/Territory of residence: _____

County of residence: _____

Delivery type: ☐ Vaginal ☐ Caesarean section

Delivery complication: ☐ No ☐ Yes

If yes, _____

Arterial Cord blood pH: *if performed* _____

Venous Cord blood pH: *if performed* _____

Placental exam (based on path report): ☐ No ☐ Yes
If yes, ☐ Normal ☐ Abruption ☐ Inflammation ☐ Other abnormality (*please describe*)

Apgar score: 1 min _____ / 5 min _____

Infant temp (*if abnormal***):** _____ °F

Physical Examination

Birth head circumference: _____☐ cm _____☐ in

☐ *molding present*

Physican report : ☐ Normal ☐ Abnormal

Birth weight:
_____☐ grams
_____☐ lbs/oz

Birth length:
_____ ☐ cm
_____☐ in

***Repeat* head circumference:**_____☐ cm _____☐ in
☐ < 24hrs ☐ 24-35hrs ☐ 36-48hrs ☐ > 48hrs
Physican report : ☐ Normal ☐ Abnormal

Admitted to Neonatal Intensive Care Unit:
☐ No ☐ Yes,
If yes, *reason* _____

Microcephaly (head circumference <3%ile): ☐ No ☐ Yes

Seizures: ☐ No ☐ Yes

Neurologic exam*: check all that apply* ☐ Not performed ☐ Unknown
☐ Normal ☐ Hypertonia/Spasticity ☐ Hyperreflexia ☐ Irritability
☐ Tremors ☐ Other Neurologic abnormalities (*please describe below*)

Splenomegaly *by physical exam*:
☐ No ☐ Yes ☐ Unknown
(please describe)

Hepatomegaly *by physical exam*:
☐ No ☐ Yes ☐ Unknown
(please describe)

Skin rash *by physical exam:*
☐ No ☐ Yes ☐ Unknown
(please describe)

Other abnormalities identified: *(please provide clinical description from medical records and include chromosomal abnormalities and syndromes); please check all that apply*

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

Approved
OMB No. 0920-1101
Exp. 08/31/2016

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☐ Microphthalmia ☐ Absent red reflex ☐ Excessive and redundant scalp skin ☐ Arthrogryposis (congenital joint contractures) ☐ Congenital Talipes Equinovarus (clubfoot)
☐ Other abnormalities (*please describe below*)

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*
☐ Microcephaly ☐ Cerebral (brain) atrophy ☐ Intracranial calcification ☐ Ventricular enlargement
☐ Lissencephaly ☐ Pachygyria ☐ Hydranencephaly ☐ Porencephaly
☐ Abnormality of corpus callosum ☐ Other abnormalities (*please describe below*)

Imaging study: ☐ Cranial ultrasound *(date: _____/_____/_____)* ☐ MRI *(date: _____/_____/_____)*
☐ CT *(date: _____/_____/_____)* ☐ Not Performed

Findings: *check all that apply*
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Infant's State/Territory ID_____ Mother's State/Territory ID _____

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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:**