CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

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 Task Force phone number: 770-488-7100

Mother's Zika virus infection (ADB follow-up)

Mother's name: _____ **Last** **First** **MI** | _____ Maiden name *(if applicable)*

State/Territory ID: _____ | **DOB:** _____/_____/_____ | **State/Territory of residence:** _____

County of residence: _____ | **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race *(check all that apply)*: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or other Pacific Islander ☐ White

Indication for maternal Zika virus testing: ☐ Exposure history, no known fetal concerns ☐ Exposure history and fetal concerns

Date of Zika virus symptom onset: _____/_____/_____ **OR-** ☐ Asymptomatic

If date not known, trimester of symptom onset _____

Hospitalized for Zika virus disease ☐ No ☐ Yes Maternal Death ☐ No ☐ Yes

Symptoms of mother's Zika virus disease: *(check all that apply)*

☐ Fever _____°F (*if measured*) ☐ Rash ☐ Arthralgia ☐ Conjunctivitis

☐ Other Clinical Presentation_____

If symptomatic, gestational age at onset: _____weeks

If gestational age not known ,trimester of symptom onset _____

Travel history: ☐ No ☐ Yes

Was Zika virus infection acquired in place of residence ☐ No ☐ Yes, *if yes, skip to the section on Mother's pregnancy*

If TRAVEL DURING PREGNANCY, answer questions below. If not, skip to non-traveling woman

Country(s) of exposure (1)_____ | **Travel start** _____/_____/_____ | **Travel end**_____/_____/_____

Mother's sexual partner(s)? *please check all that apply* ☐ Male ☐ Female

Did any male sexual partner(s) travel on this trip? ☐ No ☐ Yes ☐ Unknown

If yes, did any male partner(s) have an illness that included fever, rash, arthralgia, or conjunctivitis during or within 2 weeks of travel? ☐ No ☐ Yes ☐ Unknown

If yes, was there unprotected sexual contact while male partner(s) had illness? ☐ No ☐ Yes ☐ Unknown

If male partner(s) traveled, did he have a test that showed lab evidence of Zika? ☐ No ☐ Yes ☐ Unknown

Country(s) of exposure (2)_____ | **Travel start** _____/_____/_____ | **Travel end**_____/_____/_____

Mother's sexual partner(s)? *please check all that apply* ☐ Male ☐ Female

Did any male sexual partner(s) travel on this trip? ☐ No ☐ Yes ☐ Unknown

If yes, did any male partner(s) have an illness that included fever, rash, joint pain, or pink eye during or within 2 weeks of travel? ☐ No ☐ Yes ☐ Unknown

If yes, was there unprotected sexual contact while male partner(s) had illness? ☐ No ☐ Yes ☐ Unknown

If male partner(s) traveled, did he have a test that showed lab evidence of Zika? ☐ No ☐ Yes ☐ Unknown

Country(s) of exposure (3)_____ | **Travel start** _____/_____/_____ | **Travel end**_____/_____/_____

Mother's sexual partner(s)? *please check all that apply* ☐ Male ☐ Female

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Did any male sexual partner(s) travel on this trip? ☐ No ☐ Yes ☐ Unknown

If yes, did any male partner(s) have an illness that included fever, rash, joint pain, or pink eye during or within 2 weeks of travel? ☐ No ☐ Yes ☐ Unknown

If yes, was there unprotected sexual contact while male partner(s) had illness? ☐ No ☐ Yes ☐ Unknown

If male partner(s) traveled, did he have a test that showed lab evidence of Zika? ☐ No ☐ Yes ☐ Unknown

NON-TRAVELLING WOMAN: other possible exposures?

☐ Sexual partner w/travel history, symptomatic, lab evidence of Zika
☐ Sexual partner w/travel history, symptomatic, no test results
☐ Sexual partner w/travel history, asymptomatic, lab evidence Zika
☐ Other, please describe_____
☐ Unknown exposure history

Mother's pregnancy (DRH/DBDDD follow-up)

Last menstrual period (LMP): _____/_____/_____

Estimated delivery date: _____/_____/_____

Estimated delivery date based on (*check all that apply***):** ☐ LMP ___/___/___ ☐ U/S (1st trimester) ☐ U/S (2nd trimester) ☐ U/S (3rd trimester)

History: # pregnancies _____ # living children _____ # miscarriages _____ # elective terminations _____

Prior fetus/infant with microcephaly: ☐ No ☐ Yes **If yes, genetic cause:** ☐ No ☐ Yes

Gestation: ☐ Single ☐ Twins ☐ Triplets+

Underlying maternal illness:
Diabetes ☐ No ☐ Yes Maternal PKU ☐ No ☐ Yes Hypothyroidism ☐ No ☐ Yes Hypertension ☐ No ☐ Yes
Substance use during this pregnancy: Alcohol use ☐ No ☐ Yes Cocaine use ☐ No ☐ Yes Smoking ☐ No ☐ Yes
Other underlying illness: _____

Complications of pregnancy:
Toxoplasmosis ☐ Negative ☐ Positive ☐ Unknown Cytomegalovirus ☐ Negative ☐ Positive ☐ Unknown
Herpes Simplex ☐ Negative ☐ Positive ☐ Unknown Rubella ☐ Negative ☐ Positive ☐ Unknown
Syphilis ☐ Negative ☐ Positive ☐ Unknown

Fetal genetic abnormality ☐ No ☐ Yes, *diagnosis* _____ ☐Unknown
Gestational diabetes ☐ No ☐ Yes Pregnancy-related HTN ☐ No ☐ Yes Intrauterine death of a twin ☐ No ☐ Yes
Other _____

Medications during pregnancy: ☐ No ☐ Yes (*please list type and see guide for further instructions)*

Did this pregnancy end in miscarriage or intrauterine fetal demise (IUFD)? ☐ No ☐ Yes *Date:* _____/_____/_____
Gestational age_____ weeks

Was this pregnancy terminated? ☐ No ☐ Yes *Date:* _____/_____/_____
Gestational age_____ weeks

Maternal Prenatal Imaging and Diagnostics

Date(s) of Ultrasound(s):	
	Overall Fetal Ultrasound Results: ☐ Normal ☐ Abnormal

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____/____/____ ☐ *check if date approximated* *if date not known, gestational age* _____ *weeks*	☐ *reported by patient/healthcare provider* ☐ ultrasound report Head Circumference _____cm ☐ Normal ☐ Abnormal (*by physician report*) Biparietal diameter _____cm Femur Length _____cm Abdominal circumference _____cm ☐ Symmetrical intrauterine growth restriction (IUGR) (<5% EFW) ☐ Asymmetrical IUGR (HC<FL or HC <AC)
	Intracranial calcifications ☐ No ☐ Yes Ventriculomegaly ☐ No ☐ Yes
	Cerebral atrophy ☐ No ☐ Yes Ocular anomalies ☐ No ☐ Yes
	Cerebellar abnormalities ☐ No ☐ Yes Arthrogryposis ☐ No ☐ Yes
	Lissencephaly ☐ No ☐ Yes Pachygyria ☐ No ☐ Yes Hydranencephaly ☐ No ☐ Yes Porencephaly ☐ No ☐ Yes Corpus callosum abnormalities ☐ No ☐ Yes Hydrops ☐ No ☐ Yes
	Ascites ☐ No ☐ Yes Other ☐ No ☐ Yes, describe
Description of abnormal ultrasound findings:	
____/____/____ ☐ *check if date is approximated* *if date not known, gestational age* _____ *weeks*	**Overall Fetal Ultrasound Results:** ☐ Normal ☐ Abnormal ☐ *reported by patient/healthcare provider* ☐ ultrasound report Head Circumference _____cm ☐ Normal ☐ Abnormal (*by physician report*) Biparietal diameter _____cm Femur Length _____cm Abdominal circumference _____cm ☐ Symmetrical IUGR (<5% EFW) ☐ Asymmetrical IUGR (HC<FL or HC <AC)
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____/____/____ ☐ *check if date is approximated* *if date not known, gestational age*	**Overall Fetal Ultrasound Results:** ☐ Normal ☐ Abnormal ☐ *reported by patient/healthcare provider* ☐ ultrasound report Head Circumference _____cm ☐ Normal ☐ Abnormal (*by physician report*) Biparietal diameter _____cm Femur Length _____cm Abdominal circumference _____cm ☐ Symmetrical IUGR (<5% EFW) ☐ Asymmetrical IUGR (HC<FL or HC <AC)
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_____ *weeks*	Lissencephaly ☐ No ☐ Yes Pachygyria ☐ No ☐ Yes Hydranencephaly ☐ No ☐ Yes Porencephaly ☐ No ☐ Yes Corpus callosum abnormalities ☐ No ☐ Yes Hydrops ☐ No ☐ Yes Ascites ☐ No ☐ Yes Other ☐ No ☐ Yes, describe

Description of abnormal ultrasound findings:

For additional ultrasounds, please request a supplementary ultrasound form

Fetal MRI performed: ☐ No ☐ Yes (*please answer questions below*)

____/____/____ ☐ *check if date is approximated* *if date not known, gestational age* _____ *weeks*	**Overall Fetal MRI Results:** ☐ Normal ☐ Abnormal ☐ *reported by patient/healthcare provider* ☐ ultrasound report Head Circumference ___cm ☐ Normal ☐ Abnormal (*by physician report*) Biparietal diameter _____cm Femur Length _____cm Abdominal circumference _____cm ☐ Symmetrical IUGR (<5% EFW) ☐ Asymmetrical IUGR (HC<FL or HC <AC)
	Intracranial calcifications ☐ No ☐ Yes Ventriculomegaly ☐ No ☐ Yes
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	Ascites ☐ No ☐ Yes Other ☐ No ☐ Yes, describe

Description of abnormal MRI findings:

Amniocentesis performed: ☐ No ☐ Yes *(date: _____/_____/_____)*

Zika virus testing: ☐ Not performed ☐ Yes, *if yes test results:* ☐ negative for Zika ☐ lab evidence of Zika
Non-Zika infection detected ☐ No ☐ Yes *if yes, what infection(s) detected*_____
Genetic abnormality detected ☐ No ☐ Yes *Please Describe:*

Provider Information

Provider name: ☐ Dr. ☐ PA ☐ RN ☐ Mr. ☐ Ms. _____
Last First MI

Phone: _____ **Email:** _____ **Date of form completion**_____/_____/____

Name of person completing form: ***(if different from provider)*** _____
Last First MI

Hospital/facility:_____

Phone: _____ **Email:** _____ **Date of form completion**_____/_____/____

Health Department Information

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Name of person completing form: _____

Phone: _____ **Email:** _____ **Date of form completion**____/____/____

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Mother ID: **State/Territory ID:** **Zika T ID:**

R number: _____ **Mother infection type:** ☐ Confirmed ☐ Probable ☐ Possible