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

Reset Form

U.S. Zika Pregnancy Registry
Infant Follow-Up 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 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

Infant follow up: ☐ 2 months ☐ 6 months ☐ 12 months ☐ ___ months

IFU.1. State/Territory reporting Select State **IFU.2.** Date of infant examination _____

IFU.3. Infant's State/Territory ID	**IFU.4.** Mother's State/Territory ID	**IFU.5.** DOB:	**IFU.6.** Sex: ☐ Male ☐ Female ☐ Ambiguous/undetermined
_____	_____	_____	

IFU.7. Infant Death: ☐ No ☐ Yes **IFU.8.** If yes, cause of death _____

IFU.9. If yes, Date _____ or Age at death _____ ☐ Unknown

IFU.10. Weight:	**IFU.11.** Length:	**IFU.12.** Head circumference:
_____grams **or** ____ lbs_____ oz	_____ cm **or** _____ in	_____ cm **or** _____ in

IFU.13. Infant findings for corrected age at examination: (*For infants born preterm, please account for corrected age: chronological age minus weeks born before 40 weeks' gestation)*

Check all that apply

☐ Normal ☐ Microcephaly (head circumference <3%ile)
☐ Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)
☐ Anencephaly/ acrania ☐ Encephalocele ☐ Spina bifida
☐ Holoprosencephaly/arhinencephaly ☐ Microphthalmia/Anophthalmia
☐ Hypertonia/Spasticity ☐ Hyperreflexia ☐ Irritability ☐ Tremors
☐ Splenomegaly ☐ Hepatomegaly ☐ Skin rash
☐ Swallowing/feeding difficulties
☐ Arthrogryposis (congenital joint contractures)
☐ Congenital talipes equinovarus (clubfoot)
☐ Congenital hip dislocation/developmental dysplasia of the hip
☐ Other abnormalities

IFU.14. *Please list other abnormal findings:*

IFU.15. Development assessment for corrected age at examination: (*For infants born preterm, please account for corrected age: chronological age minus weeks born before 40 weeks' gestation)*
☐ Normal ☐ Abnormal ☐ Unknown

IFU.16. If developmental delay, in what area? *Please check all that apply*
☐ Gross motor ☐ Fine motor ☐ Cognitive, linguistic and communication ☐ Socio-Emotional

Special Studies Since Last Follow-up

IFU.17. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Other _____
☐ Not Performed ☐ Unknown

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

IFU.18. Date: _____

IFU.19. Findings: *check all that apply* ☐ Normal

☐ Microcephaly ☐ Intracranial calcifications ☐ 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

IFU.20. *Please describe below*

IFU.21. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Other _____

☐ Not Performed ☐ Unknown

IFU.22. Date: _____

IFU.23. Findings: *check all that apply* ☐ Normal

☐ Microcephaly ☐ Intracranial calcifications ☐ 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

IFU.24. (*please describe below*)

IFU.25. Hearing screening or re-screening: ☐ Not performed ☐ Performed ☐ Unknown
IFU.26. *If performed:* Date: _____ **IFU.27.** ☐ Pass ☐ Fail or referred,
IFU.28. *Please describe*

IFU.29. Audiological evaluation: ☐ Not performed ☐ Performed ☐ Unknown
IFU.30. *If performed:* Date: _____ **IFU.31.** ☐ Normal ☐ Abnormal,
IFU.32. *Please describe*

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

IFU.33. Retinal exam (with dilation): ☐ Not Performed ☐ Performed ☐ Unknown

IFU.34. *If performed:* Date: _____

IFU.35. Findings: *Check all that apply:*

☐ 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

IFU.36. *Please describe*

IFU.37. Other abnormal tests/results/diagnosis (include dates): ☐ No ☐ Yes

IFU.38. Date: _____

IFU.39. *Please describe*

Health Department Information

IFU.40. Name of person completing form: _____

IFU.41. Phone: _____ **IFU.42.** Email: _____

IFU.43. Date of form completion_____

Internal use only

Date entered_____ ***Data Entry POC Initials:*** _____	***Data Entry Notes*:**