Government of the District of Columbia
Department of Health
Pregnancy and Zika virus disease surveillance form

These data are considered confidential and will be stored in a secure database at the Distrcit of Columbia Department of Health and Centers for Disease Control and Prevention

Please return completed form by fax to the secure number: 202-442-8060. For questions email: DOH.EPI@dc.gov or call: 844-493-2652.

Neonate Assessment

Infant's name: _____
Last First MI

Birth Certificate ID: _____

Infant's DC DOH Z Number: _____

Mother's DC DOH Z Number: _____

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 (or DC Ward) 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 *(please include any abnormal findings noted during admission): check all that apply*

☐ Not performed ☐ Unknown ☐ Hyperreflexia ☐ Irritability

☐ Normal ☐ Hypertonia/Spasticity ☐ Hypotonia

☐ Tremors

☐ Other Neurologic abnormalities (*please describe*):

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 DC DOH Z Number_____ Mother's DC DOH Z Number_____

Pregnancy and Zika virus disease surveillance form

Please return completed form by fax to the secure number: 202-442-8060. For questions email: DOH.EPI@dc.gov or call: 844-493-2652.

☐ 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*
☐ 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*
☐ Microcephaly ☐ Cerebral (brain) atrophy ☐ Intracranial calcification ☐ Ventricular enlargement

Infant's DC DOH Z Number_____ Mother's DC DOH Z Number_____

Pregnancy and Zika virus disease surveillance form

Please return completed form by fax to the secure number: 202-442-8060. For questions email: DOH.EPI@dc.gov or call: 844-493-2652.

☐ 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)