



## U.S. Zika Pregnancy and Infant 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](mailto:ZIKApregnancy@cdc.gov)

1. General, Growth and Travel Information			
Infant follow up: <input type="checkbox"/> 2 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> 18 months <input type="checkbox"/> 24 months <input type="checkbox"/> _____ months			
<b>IFU.1.</b> State/Territory reporting: _____			
<b>IFU.2.</b> Infant's State/Territory ID _____	<b>IFU.3.</b> Mother's State/Territory ID _____	<b>IFU.4.</b> DOB: _____	<b>IFU.5.</b> Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous/undetermined
Infant death			
<b>IFU.6.</b> Infant Death: <input type="checkbox"/> No <input type="checkbox"/> Yes			
<b>IFU.7.</b> If yes, cause of death: _____			
<b>IFU.8.</b> If yes, date of death: _____ or Age at death _____ <input type="checkbox"/> Unknown/Not stated			
Growth			
<b>IFU.9.</b> Weight: _____ grams or _____ lbs _____ oz	<b>IFU.11.</b> Length: _____ cm or _____ in	<b>IFU.13.</b> Head circumference: _____ cm or _____ in	
<b>IFU.10.</b> Date of measurement: _____	<b>IFU.12.</b> Date of measurement: _____	<b>IFU.14.</b> Date of measurement: _____	

<i>Optional Section</i>		
<b>Postnatal travel</b> <i>Only complete if infant received PRNT testing</i>		
<b>IFU.15.</b> Postnatal travel to an area with active Zika virus transmission <i>mark one</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown/Not stated		
<b>IFU.16.</b> Location of exposure (1) _____	<b>IFU.17.</b> Start Date _____	<b>IFU.18.</b> End Date _____
<b>IFU.19.</b> Location of exposure (2) _____	<b>IFU.20.</b> Start Date _____	<b>IFU.21.</b> End Date _____
<b>IFU.22.</b> Location of exposure (3) _____	<b>IFU.23.</b> Start Date _____	<b>IFU.24.</b> End Date _____

## 2. Neurologic Sequelae

### Physical exam or neurological evaluation

**IFU.25.** Physical exam or neurological evaluation performed: *mark one*

- Yes - *If "Yes", complete the section below*
- No - *If "No", skip to "Developmental Assessment" (page 3)*
- Unknown/Not Stated – *If "Unknown/Not stated", skip to "Developmental Assessment" (page 3)*

**IFU.26.** Date of exam or evaluation: \_\_\_\_\_

**IFU.27.** Findings from physical exam or neurological evaluation: *check all that apply*

Normal

#### Neurologic sequelae

Seizures

#### Body tone abnormalities

Hypertonia/spasticity

Hyperreflexia

Hypotonia

#### Movement abnormalities

Dyskinesia or dystonia

Tremors

Swallowing/feeding difficulties

#### Signs of possible visual impairment

Failure to fix and follow

Nystagmus

Esotropia/Strabismus

Irritability

#### Contractures with brain anomalies

Arthrogyposis (congenital joint contractures)

Congenital talipes equinovarus (clubfoot)

Congenital hip dislocation/developmental dysplasia of the hip

Fetal brain disruption sequence

Collapsed skull/ prominent occipital bone

Scalp rugae/ excessive scalp skin

Other abnormalities - *Please describe:*

**IFU.28.** Describe findings identified in **IFU.27.:**

**3. Developmental Assessment****IFU.29.** Overall interpretation of development: *mark one*

- Normal - *If "Normal", complete the section below*
- Abnormal - *If "Abnormal", complete the section below*
- Unknown/Not stated - *If "Unknown/Not stated", skip to "Neurological Imaging Studies" (page 4)*

**IFU.30.** Date of exam: \_\_\_\_\_**IFU.31.** Areas of developmental delay: *check all that apply*     No delays

- Gross motor     Fine motor     Cognitive- linguistic and communication     Socio-Emotional

**IFU.32.** Describe all abnormal findings:**IFU.33.** Standardized developmental assessment or evaluation performed: *mark one*

- Yes *If "Yes", IFU.34. Type of assessment: \_\_\_\_\_*
- No
- Unknown/Not stated

#### 4. Neurological Imaging Studies – findings of congenital anomalies of the brain/spinal cord

**IFU.35.** Neurological imaging studies performed: *mark one*

- Yes - *If “Yes”, complete the section below*
- No - *If “No”, skip to “Audiological Screening and Evaluation” (page 5)*
- Unknown/Not stated - *If “Unknown/Not stated”, skip to “Audiological Screening and Evaluation” (page 5)*

**IFU.36.** Neurological imaging type: *mark one*     Cranial ultrasound     MRI     CT

Other: \_\_\_\_\_

**IFU.37.** Date of imaging: \_\_\_\_\_

**IFU.38.** Findings from neurological imaging study: *check all that apply*

- |  |   |
|--|---|
| <input type="checkbox"/> Normal  | <input type="checkbox"/> Porencephaly                                     |
| <input type="checkbox"/> Microcephaly  | <input type="checkbox"/> Hydranencephaly                                  |
| <input type="checkbox"/> Intracranial calcifications   | <input type="checkbox"/> Moderate or severe ventriculomegaly/hydrocephaly |
| <input type="checkbox"/> Cerebral/cortical atrophy   | <input type="checkbox"/> Encephalocele                                    |
| <input type="checkbox"/> Abnormal cortical formation<br>(polymicrogyria, lissencephaly,<br>pachygyria, schizencephaly, gray<br>matter heterotopia, agyria, microgyria) | <input type="checkbox"/> Holoprosencephaly/ arhinencephaly                |
| <input type="checkbox"/> Corpus callosum abnormalities   | <input type="checkbox"/> Other abnormalities - <i>Please describe:</i>    |
| <input type="checkbox"/> Cerebellar abnormalities  |   |

**IFU.39.** Describe all findings identified in IFU.38.:

**IFU.40.** Neurological imaging type: *mark one*     Cranial ultrasound     MRI     CT

Other: \_\_\_\_\_

**IFU.41.** Date of imaging: \_\_\_\_\_

**IFU.42.** Findings from neurological imaging study: *check all that apply*

- |  |   |
|--|---|
| <input type="checkbox"/> Normal  | <input type="checkbox"/> Porencephaly                                     |
| <input type="checkbox"/> Microcephaly  | <input type="checkbox"/> Hydranencephaly                                  |
| <input type="checkbox"/> Intracranial calcifications   | <input type="checkbox"/> Moderate or severe ventriculomegaly/hydrocephaly |
| <input type="checkbox"/> Cerebral/cortical atrophy   | <input type="checkbox"/> Encephalocele                                    |
| <input type="checkbox"/> Abnormal cortical formation<br>(polymicrogyria, lissencephaly,<br>pachygyria, schizencephaly, gray<br>matter heterotopia, agyria, microgyria) | <input type="checkbox"/> Holoprosencephaly/ arhinencephaly                |
| <input type="checkbox"/> Corpus callosum abnormalities   | <input type="checkbox"/> Other abnormalities - <i>Please describe:</i>    |
| <input type="checkbox"/> Cerebellar abnormalities  |   |

**IFU.43.** Describe all findings identified in IFU.42.:

## 5. Audiological Screening and Evaluation

**Hearing screening or re-screening**, excluding birth hospitalization hearing screening

**IFU.44.** Hearing screening performed: *mark one*

- Yes - *If "Yes", complete the section below*
- No - *If "No", skip to "Audiological evaluation" (page 5)*
- Unknown/Not stated - *If "Unknown/Not Stated", skip to "Audiological Evaluation" (page 5)*

**IFU.45.** Date of screening: \_\_\_\_\_

**IFU.46.** Hearing screening results: *mark one*

- Pass    Fail or referred    Unknown/Not stated

**IFU.47.** If hearing screening failed, specify: *mark one*

- Abnormal, unilateral    Abnormal, bilateral
- Abnormal, laterality unknown/not stated

**IFU.48.** Provide any additional comments from hearing screening:

### Audiological evaluation

**IFU.49.** Audiological evaluation performed: *mark one*

- Yes - *If "Yes", complete the section below*
- No - *If "No", skip to "Congenital Anomalies of the Eye" (page 6)*
- Unknown/Not stated - *If "Unknown/Not Stated", skip to "Congenital Anomalies of the Eye" (page 6)*

**IFU.50.** Date of evaluation: \_\_\_\_\_

**IFU.51.** Overall interpretation of audiological evaluation: *mark one*  Unknown/Not stated

- Normal    Abnormal, unilateral    Abnormal, bilateral    Abnormal, laterality not stated

**IFU.52.** If overall interpretation is abnormal, indicate type(s) of hearing loss and severity of hearing loss:  
*mark all that apply*

*Type of hearing loss – mark all that apply*

- Conductive hearing loss
- Sensorineural hearing loss
- Mixed hearing loss
- Auditory neuropathy spectrum disorder
- Hearing loss, type unknown/not stated

*Severity of hearing loss – mark all that apply*

- Mild
- Moderate
- Moderately severe
- Severe
- Profound
- Severity unknown/not stated

**IFU.53.** Provide any additional comments from audiological evaluation:

**6. Congenital Anomalies of the Eye****IFU.54.** Retinal exam: *mark one*

- Yes - *If "Yes", complete the section below*
- No - *If "No", skip to "Additional Studies and Evaluation" (page 7)*
- Unknown/Not stated - *If "Unknown/Not stated", skip to "Additional Studies and Evaluation" (page 7)*

**IFU.55.** Date of exam: \_\_\_\_\_**IFU.56.** Overall eye findings: *mark one*  Unknown/Not stated Normal  Abnormal, unilateral  Abnormal, bilateral  Abnormal, laterality not stated**IFU.57.** Visual acuity/impairment: *mark one*  Unknown/Not stated Normal  Abnormal, unilateral  Abnormal, bilateral  Abnormal, laterality not stated**IFU.58.** If eye findings are abnormal, indicate all abnormal findings: *check all that apply* Microphthalmia/anophthalmia Cataract Intraocular calcifications Coloboma Coloboma of the iris Coloboma of the retina or optic nerve Chorioretinal anomalies involving the macula (e.g., chorioretinal atrophy and scarring, macular pallor, gross pigmentary mottling) Optic nerve atrophy, pallor Other optic nerve abnormalities - *Please describe:***IFU.59.** Describe all findings identified in **IFU.56.– IFU.58.:**

**7. Additional Studies and Evaluation**

**IFU.60.** Other studies performed: *mark one*

- Yes - *If "Yes", complete the section below*
- No - *If "No", skip to "Health Department Information" (page 7)*
- Unknown/Not stated - *If "Unknown/Not stated", skip to "Health Department Information" (page 7)*

**IFU.61.** Study type: *mark one*     Electroencephalogram (EEG)     Swallowing evaluation     Hip ultrasound  
 Other: \_\_\_\_\_

**IFU.62.** Date of study: \_\_\_\_\_

**IFU.63.** Overall interpretation: *mark one*     Normal     Abnormal     Unknown/Not stated

**IFU.64.** Describe abnormal findings:

**IFU.65.** Study type: *mark one*     Electroencephalogram (EEG)     Swallowing evaluation     Hip ultrasound  
 Other: \_\_\_\_\_

**IFU.66.** Date of study: \_\_\_\_\_

**IFU.67.** Overall interpretation: *mark one*     Normal     Abnormal     Unknown/Not stated

**IFU.68.** Describe abnormal findings:

**8. Health Department Information**

Name of person completing form: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Date of form completion: \_\_\_\_\_

**Internal use only**

<b>Date entered</b> _____	<b>Data Entry Notes:</b>
<b>Data Entry POC Initials:</b>	

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)

**END**