



Infant's State/Territory ID (VA Zika ID) _____

Mother's State/Territory ID (VA Zika ID) _____

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

Infant Follow-up Pregnancy and Zika Virus Disease Surveillance Form US Zika Pregnancy Registry

Data is considered confidential and will be stored in a secure database at the Centers for Disease Control and Prevention and the Virginia Department of Health.

Healthcare Provider: Please return completed form to the Fairfax County Health Department by fax **703-653-1347** or encrypted email (password protected) **hdcd@fairfaxcounty.gov**

Infant follow up: 2 months 6 months 12 months

Imaging study: Cranial ultrasound (date: ___/___/___) MRI (date: ___/___/___)
 CT (date: ___/___/___) Other _____ Not Performed

Findings: *check all that apply*

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Microcephaly | <input type="checkbox"/> Cerebral (brain) atrophy | <input type="checkbox"/> Intracranial calcification | <input type="checkbox"/> Ventricular enlargement |
| <input type="checkbox"/> Lissencephaly | <input type="checkbox"/> Pachygyria | <input type="checkbox"/> Hydranencephaly | <input type="checkbox"/> Porencephaly |
| <input type="checkbox"/> Abnormality of corpus callosum | <input type="checkbox"/> Other abnormalities (<i>please describe below</i>) | | |

Hearing screening or re-screening: Not performed Unknown
If performed: (date: ___/___/___) Pass Fail or referred, *please describe*

Audiological evaluation: Not performed Unknown
If performed: (date: ___/___/___) Normal Abnormal, *please describe*

Retinal exam (with dilation): Not Performed Unknown
If performed: please check all that apply: (date: ___/___/___)
 Microphthalmia Chorioretinitis Macular pallor Other retinal abnormalities(*please describe below*)

Other abnormal tests/results/diagnosis (include dates): No Yes (date: ___/___/___)
 please describe

Health Department Information

LHD: After reviewing the form and entering the information into VEDSS, please upload the form to shared drive/SharePoint and notify VDH Office of Family Health Services (Jennifer MacDonald at Jennifer.macdonald@vdh.virginia.gov).

Name of person completing form: _____
Phone: _____ **Email:** _____ **Date of form completion** ___/___/___

FOR INTERNAL CDC USE ONLY
Mother ID: _____

State/territory ID: _____



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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)