



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**

Mother's Zika virus infection <input type="checkbox"/> Initial ID <input type="checkbox"/> 24 weeks <input type="checkbox"/> 35 weeks		
State/Territory ID (VA ZIKA ID): _____	Maternal Age at Diagnosis: _____	State/Territory of residence: _____
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		
Race (check all that apply): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White		
Indication for maternal Zika virus testing: <input type="checkbox"/> Exposure history, no known fetal concerns <input type="checkbox"/> Exposure history and fetal concerns		
Date of Zika virus symptom onset: ____/____/____ OR- <input type="checkbox"/> Asymptomatic If date not known, trimester of symptom onset _____		
Hospitalized for Zika virus disease <input type="checkbox"/> No <input type="checkbox"/> Yes Maternal Death <input type="checkbox"/> No <input type="checkbox"/> Yes		
Symptoms of mother's Zika virus disease: (check all that apply) <input type="checkbox"/> Fever ____°F (if measured) <input type="checkbox"/> Rash <input type="checkbox"/> Arthralgia <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Other Clinical Presentation _____		
If symptomatic, gestational age at onset: _____ weeks If gestational age not known, trimester of symptom onset _____		Travel history: <input type="checkbox"/> No <input type="checkbox"/> Yes
Was Zika virus infection acquired in place of residence <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> Male <input type="checkbox"/> Female		
Did any male sexual partner(s) travel on this trip? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
If yes, was there unprotected sexual contact while male partner(s) had illness? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
If male partner(s) traveled, did he have a test that showed lab evidence of Zika? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
Country(s) of exposure (2) _____	Travel start ____/____/____	Travel end ____/____/____
Mother's sexual partner(s)? please check all that apply <input type="checkbox"/> Male <input type="checkbox"/> Female		
Did any male sexual partner(s) travel on this trip? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
If yes, was there unprotected sexual contact while male partner(s) had illness? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
If male partner(s) traveled, did he have a test that showed lab evidence of Zika? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown		
Country(s) of exposure (3) _____	Travel start ____/____/____	Travel end ____/____/____
Mother's sexual partner(s)? please check all that apply <input type="checkbox"/> Male <input type="checkbox"/> Female		



State/Territory ID (VA ZIKA ID) _____

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

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Did any male sexual partner(s) travel on this trip? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
If yes, was there unprotected sexual contact while male partner(s) had illness? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
If male partner(s) traveled, did he have a test that showed lab evidence of Zika? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
NON-TRAVELLING WOMAN: other possible exposures?	
<input type="checkbox"/> Sexual partner w/travel history, symptomatic, lab evidence of Zika <input type="checkbox"/> Sexual partner w/travel history, symptomatic, no test results <input type="checkbox"/> Sexual partner w/travel history, <u>asymptomatic</u> , lab evidence Zika <input type="checkbox"/> Other, please describe _____ <input type="checkbox"/> Unknown exposure history	
Pregnancy Information	
Last menstrual period (LMP): ____/____/____	Estimated delivery date: ____/____/____
Estimated delivery date based on (check all that apply):	
<input type="checkbox"/> LMP ____/____/____	<input type="checkbox"/> U/S (1 st trimester)
<input type="checkbox"/> U/S (2 nd trimester)	<input type="checkbox"/> U/S (3 rd trimester)
History: # pregnancies ____ # living children ____ # miscarriages ____ # elective terminations ____	
Prior fetus/infant with microcephaly: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, genetic cause: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Gestation: <input type="checkbox"/> Single <input type="checkbox"/> Twins <input type="checkbox"/> Triplets+	
Underlying maternal illness:	
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes Maternal PKU <input type="checkbox"/> No <input type="checkbox"/> Yes Hypothyroidism <input type="checkbox"/> No <input type="checkbox"/> Yes Hypertension <input type="checkbox"/> No <input type="checkbox"/> Yes	
Substance use during this pregnancy: Alcohol use <input type="checkbox"/> No <input type="checkbox"/> Yes Cocaine use <input type="checkbox"/> No <input type="checkbox"/> Yes Smoking <input type="checkbox"/> No <input type="checkbox"/> Yes	
Other underlying illness: _____	
Complications of pregnancy:	
Toxoplasmosis <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Unknown	Cytomegalovirus <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Unknown
Herpes Simplex <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Unknown	Rubella <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Unknown
Syphilis <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Unknown	
Fetal genetic abnormality <input type="checkbox"/> No <input type="checkbox"/> Yes, <i>diagnosis</i> _____ <input type="checkbox"/> Unknown	
Gestational diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes Pregnancy-related HTN <input type="checkbox"/> No <input type="checkbox"/> Yes Intrauterine death of a twin <input type="checkbox"/> No <input type="checkbox"/> Yes	
Other _____	
Medications during pregnancy: <input type="checkbox"/> No <input type="checkbox"/> Yes (please list type and see guide for further instructions)	
Did this pregnancy end in miscarriage or intrauterine fetal demise (IUFD)? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: ____/____/____ Gestational age _____ weeks	Was this pregnancy terminated? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: ____/____/____ Gestational age _____ weeks
If pregnancy resulted in live birth,	
(1) Child's date of birth _____ Name: _____ Virginia Zika ID: _____	



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(2) Child's date of birth _____ Name: _____ Virginia Zika ID: _____
(3) Child's date of birth _____ Name: _____ Virginia Zika ID: _____

Maternal Prenatal Imaging and Diagnostics

Date(s) of
Ultrasound(s):

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

Description of abnormal ultrasound findings:

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

Description of abnormal ultrasound findings:



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____/____/____ <input type="checkbox"/> check if date is approximated if date not known, gestational age _____ weeks	Overall Fetal Ultrasound Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> reported by patient/healthcare provider <input type="checkbox"/> ultrasound report
	Head Circumference ____cm <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (by physician report) Biparietal diameter ____cm Femur Length ____cm Abdominal circumference ____cm <input type="checkbox"/> Symmetrical IUGR (<5% EFW) <input type="checkbox"/> Asymmetrical IUGR (HC<FL or HC <AC)
	Intracranial calcifications <input type="checkbox"/> No <input type="checkbox"/> Yes Ventriculomegaly <input type="checkbox"/> No <input type="checkbox"/> Yes
	Cerebral atrophy <input type="checkbox"/> No <input type="checkbox"/> Yes Ocular anomalies <input type="checkbox"/> No <input type="checkbox"/> Yes
	Cerebellar abnormalities <input type="checkbox"/> No <input type="checkbox"/> Yes Arthrogryposis <input type="checkbox"/> No <input type="checkbox"/> Yes
	Lissencephaly <input type="checkbox"/> No <input type="checkbox"/> Yes Pachygyria <input type="checkbox"/> No <input type="checkbox"/> Yes Hydranencephaly <input type="checkbox"/> No <input type="checkbox"/> Yes Porencephaly <input type="checkbox"/> No <input type="checkbox"/> Yes Corpus callosum abnormalities <input type="checkbox"/> No <input type="checkbox"/> Yes Hydrops <input type="checkbox"/> No <input type="checkbox"/> Yes
	Ascites <input type="checkbox"/> No <input type="checkbox"/> Yes Other <input type="checkbox"/> No <input type="checkbox"/> 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)

____/____/____ <input type="checkbox"/> check if date is approximated if date not known, gestational age _____ weeks	Overall Fetal MRI Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> reported by patient/healthcare provider <input type="checkbox"/> ultrasound report
	Head Circumference ____cm <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (by physician report) Biparietal diameter ____cm Femur Length ____cm Abdominal circumference ____cm <input type="checkbox"/> Symmetrical IUGR (<5% EFW) <input type="checkbox"/> Asymmetrical IUGR (HC<FL or HC <AC)
	Intracranial calcifications <input type="checkbox"/> No <input type="checkbox"/> Yes Ventriculomegaly <input type="checkbox"/> No <input type="checkbox"/> Yes
	Cerebral atrophy <input type="checkbox"/> No <input type="checkbox"/> Yes Ocular anomalies <input type="checkbox"/> No <input type="checkbox"/> Yes
	Cerebellar abnormalities <input type="checkbox"/> No <input type="checkbox"/> Yes Arthrogryposis <input type="checkbox"/> No <input type="checkbox"/> Yes
	Lissencephaly <input type="checkbox"/> No <input type="checkbox"/> Yes Pachygyria <input type="checkbox"/> No <input type="checkbox"/> Yes Hydranencephaly <input type="checkbox"/> No <input type="checkbox"/> Yes Porencephaly <input type="checkbox"/> No <input type="checkbox"/> Yes Corpus callosum abnormalities <input type="checkbox"/> No <input type="checkbox"/> Yes Hydrops <input type="checkbox"/> No <input type="checkbox"/> Yes
	Ascites <input type="checkbox"/> No <input type="checkbox"/> Yes Other <input type="checkbox"/> No <input type="checkbox"/> 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:



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LHD: After reviewing the form and entering 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: _____ Zika T ID: _____

R number: _____ Mother infection type: Confirmed Probable Possible

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).