

THE U.S. ZIKA PREGNANCY REGISTRY

CALIFORNIA DATA SUBMISSION PROCESS

Neonate Assessment Form

The California Department of Public Health (CDPH) is participating in the U.S. Zika Pregnancy Registry and is the point of contact for California data submission to the Centers for Disease Control and Prevention (CDC).

If you require this document in an alternate format, please contact ZikaOutcomes@cdph.ca.gov.

Who Is Eligible for the Registry?

- Pregnant women in the United States with laboratory evidence of Zika virus infection (positive or equivocal test results, regardless of whether they have symptoms) and periconceptionally, prenatally, or perinatally exposed infants born to these women.
- Infants with laboratory evidence of congenital Zika virus infection (positive or equivocal test results, regardless of whether they have symptoms) and their mothers.

To participate, follow the directions below:

Healthcare Provider Instructions	Local Health Department Instructions
<ul style="list-style-type: none"> ▪ Healthcare providers should contact their Local Health Department (LHD) for questions about data submission. ▪ Providers may be contacted by either the LHD or CDPH for Zika pregnancy and infant outcomes data collection. ▪ Visit the US Zika Pregnancy Registry webpage for more information on reporting Zika pregnancy and infant outcomes to CDPH. 	<ul style="list-style-type: none"> ▪ Local Health Departments may choose to follow up with healthcare providers or ask CDPH staff to follow-up. LHDs should inform CDPH of the LHD preference at: ZikaOutcomes@cdph.ca.gov. ▪ Various methods (e.g., medical record abstraction, telephone interview) can be used to collect surveillance information for the Registry. ▪ LHDs contacting providers to complete the Registry forms directly should insert the LHD contact information below for provider submission. ▪ LHDs should ensure completion of the attached form and then submit to CDPH by e-mail or fax as instructed below.

FORM PROCESSING INSTRUCTIONS

Send Registry forms to:

California Department of Public Health

Fax: (510) 620-3152

Phone: (510) 620-3151

Email: ZikaOutcomes@cdph.ca.gov

(Please send a message for instructions **before** submission).

My Local Health Department at the address below:

Phone: _____

Security note:

-Call prior to faxing forms to CDPH or Local Health Department.

*-Please **DO NOT** scan and email documents before receiving instructions.*

HIPAA Privacy Rule permits providers to disclose PHI without authorization to public health authorities for the purposes of preventing or controlling disease.

The CDPH California Birth Defects Monitoring Program (CBDMP) is authorized to conduct studies to investigate the causes of birth defects (H&S section 103840).





U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Neonate Assessment Form

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Please return completed form via secure fax to 510-620-3152 or encrypted email to ZikaOutcomes@cdph.ca.gov

NAD.1. Infant's State/Territory ID _____	NAD.2. Mother's State/Territory ID _____	NAD.3. DOB: _____ <input type="checkbox"/> Live birth <input type="checkbox"/> Stillbirth ≥20 weeks	NAD.4. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous/undetermined
NAD.5. Gestational age at delivery: _____ weeks _____ days	NAD.6. Based on: (check all that apply) <input type="checkbox"/> LMP Date: _____ <input type="checkbox"/> 1 st trimester ultrasound <input type="checkbox"/> 2 nd trimester ultrasound <input type="checkbox"/> 3 rd trimester ultrasound <input type="checkbox"/> Other _____		NAD.7. Maternal age at delivery ____ years
NAD.8. State/Territory reporting: _____		NAD.9. County reporting: _____	
NAD.10. Delivery type: <input type="checkbox"/> Vaginal <input type="checkbox"/> Caesarean section NAD.11. Delivery complication: <input type="checkbox"/> No <input type="checkbox"/> Yes NAD.12. If yes, please describe: _____		NAD.13. Arterial cord blood pH (if performed): _____ NAD.14. Venous cord blood pH (if performed): _____	
NAD.15. Placental exam (based on path report): <input type="checkbox"/> No <input type="checkbox"/> Yes NAD.16. If yes, <input type="checkbox"/> Normal <input type="checkbox"/> Abruptio <input type="checkbox"/> Inflammation <input type="checkbox"/> Other abnormality (please describe)			
NAD.17. Apgar score: 1 min _____ / 5 min _____		NAD.18. Infant temp (if abnormal): _____ °F or _____ °C	
Physical Examination (record earliest measurements taken)			
NAD.19. Birth head circumference: _____ <input type="checkbox"/> cm _____ <input type="checkbox"/> in NAD.20. <input type="checkbox"/> Molding present NAD.21. Physican report: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal NAD.22. HC percentile: _____		NAD.23. Birth weight: _____ <input type="checkbox"/> grams _____ <input type="checkbox"/> lbs/oz NAD.24. Birth weight percentile: _____	
NAD.25. Birth length: _____ <input type="checkbox"/> cm _____ <input type="checkbox"/> in NAD.26. Birth length percentile: _____		NAD.27. Repeat head circumference: _____ <input type="checkbox"/> cm _____ <input type="checkbox"/> in NAD.28. Date performed: _____ or Age _____ day(s) NAD.29. Physican report: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal NAD.30. HC percentile: _____	
NAD.31. Admitted to Neonatal Intensive Care Unit: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, reason:</i> _____		NAD.32. Neonatal death: <input type="checkbox"/> No <input type="checkbox"/> Yes NAD.33. Date: _____ or Age at death _____ days NAD.34. Cause of death: _____	
NAD.35. Microcephaly (head circumference <3%ile): <input type="checkbox"/> No <input type="checkbox"/> Yes		NAD.36. Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes	
NAD.37. Neurologic exam: (check all that apply) <input type="checkbox"/> Not performed <input type="checkbox"/> Unknown <input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia/Spasticity <input type="checkbox"/> Hyperreflexia <input type="checkbox"/> Irritability <input type="checkbox"/> Tremors <input type="checkbox"/> Other neurologic abnormalities NAD.38. (please describe below)			



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<p>NAD.39. Splenomegaly by physical exam: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown NAD.40. (please describe)</p>	<p>NAD.41. Hepatomegaly by physical exam: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown NAD.42. (please describe)</p>	<p>NAD.43. Skin rash by physical exam: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown NAD.44. (please describe)</p>
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NAD.45. Other abnormalities identified: please check all that apply

Fetal Brain Disruption Sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)
 Encephalocele Anencephaly/ Acrania Spina bifida Holoprosencephaly/arhinencephaly
 Microphthalmia/Anophthalmia Arthrogryposis (congenital joint contractures)
 Congenital Talipes Equinovarus (clubfoot) Congenital hip dislocation/developmental dysplasia of the hip
 Other abnormalities
NAD.46. (please describe below)

Neonate Imaging and Diagnostics

NAD.47. Hearing screening : (Date: _____) or Age _____ day(s)

NAD.48. Pass Fail Inconclusive/Needs retest Not performed

NAD.49. Please describe

NAD.50. Audiological evaluation: Not performed Auditory brainstem response (ABR) test performed
 Otoacoustic emissions (OAE) test performed Acoustic stapedius reflex (ASR) test performed
 Unknown

NAD.51. If performed: Date: _____ **NAD.52.** Normal Abnormal

NAD.53. Please describe

NAD.54. Retinal exam (with dilation): Not Performed Performed Unknown

NAD.55. If performed: (Date: _____) or Age _____ day(s)

NAD.56. please check all that apply: Normal

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
NAD.57. (please describe below)

NAD.58. Imaging study: Cranial ultrasound MRI CT Not Performed

NAD.59. (Date: _____) or Age _____ day(s)

NAD.60. Findings: check all that apply Normal

Microcephaly Intracranial calcification Cerebral / cortical atrophy



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- 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
- NAD.61.** *(please describe below)*

- NAD.62. Imaging study:** Cranial ultrasound MRI CT Not Performed
- NAD.63.** (Date: _____) or Age _____ day(s)
- NAD.64. Findings:** *check all that apply* Normal
- Microcephaly Intracranial calcification 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
- NAD.65.** *(please describe below)*

- NAD.66. Imaging study:** Cranial ultrasound MRI CT Not Performed
- NAD.67.** (Date: _____) or Age _____ day(s)
- NAD.68. Findings:** *check all that apply* Normal
- Microcephaly Intracranial calcification 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

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



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Other abnormalities
NAD.69. (please describe below)

NAD.70. Was a lumbar puncture performed: Yes No Unknown **NAD.71.** (Date: _____)
 or Age _____ day(s)

Postnatal Infection Testing (includes urine culture for CMV)

NAD.72.	Toxoplasmosis infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
NAD.73.	Cytomegalovirus infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
NAD.74.	Herpes Simplex infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
NAD.75.	Rubella infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
NAD.76.	Lymphocytic choriomeningitis virus infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
NAD.77.	Syphilis infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown

NAD.78. If yes for any postnatal infection testing, please describe results:

Postnatal (Infant) Cytogenetic Testing

NAD.79. Cytogenetic Test	NAD.80. Date:	NAD.82. Specimen	NAD.83. Test Result
<input type="checkbox"/> Karyotype <input type="checkbox"/> FISH <input type="checkbox"/> CGH microarray <input type="checkbox"/> Other, specify _____	_____ NAD.81. Infant Age: _____ months	<input type="checkbox"/> Cord blood <input type="checkbox"/> Peripheral blood <input type="checkbox"/> Tissue <input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown

NAD.84. Description of cytogenetic test findings (verbatim):

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



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NAD.85. Other tests/results/diagnosis (include dates):

Birth Defects Diagnosed or Suspected (Include Chromosomal Abnormalities and Syndromes)

Diagnostic Code	Certainty	Verbatim Description
	Definite Possible/Probable	
	<input type="checkbox"/> Definite <input type="checkbox"/> Possible/Probable	
	<input type="checkbox"/> Definite <input type="checkbox"/> Possible/Probable	
	<input type="checkbox"/> Definite <input type="checkbox"/> Possible/Probable	
	<input type="checkbox"/> Definite <input type="checkbox"/> Possible/Probable	
	<input type="checkbox"/> Definite <input type="checkbox"/> Possible/Probable	

Health Department Information

NAD.86. Name of person completing form: _____
NAD.87. Phone: _____
NAD.88. Email: _____ **NAD.89. 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)