

THE U.S. ZIKA PREGNANCY REGISTRY

CALIFORNIA DATA SUBMISSION PROCESS

Supplemental Maternal Prenatal Imaging & Diagnostics 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 Supplemental Maternal Prenatal Imaging and Diagnostics 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 secure fax to 510-620-3152 or encrypted email to ZikaOutcomes@cdph.ca.gov

SIF.1. State/Territory ID: _____		SIF.2. State/Territory reporting: _____		
		SIF.3. County reporting: _____		
SIF.4. Date(s) of ultrasound(s): _____ <input type="checkbox"/> SIF.5. Check if date approximated SIF.6. If date not known, Gestational age _____ weeks) (days)	SIF.7. Overall fetal ultrasound results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
	SIF.8. <input type="checkbox"/> Reported by patient/healthcare provider <input type="checkbox"/> Ultrasound report			
	SIF.9. Head circumference (HC) _____ cm			
	SIF.10. <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (<i>by physician report</i>)			
	SIF.11. Biparietal diameter (BPD) _____ cm			
	SIF.12. Femur length (FL) _____ cm			
	SIF.13. Abdominal circumference (AC) _____ cm			
	SIF.14. <input type="checkbox"/> Symmetric intrauterine growth restriction (IUGR) <input type="checkbox"/> Asymmetric IUGR (HC>AC or HC>FL)			
	SIF.15. Microcephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.16. Intracranial calcifications	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.17. Cerebral / cortical atrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.18. Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.19. Corpus callosum abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.20. Cerebellar abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.21. Porencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.22. Hydranencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.23. Moderate or severe ventriculomegaly/hydrocephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.24. Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.25. Other major brain abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.26. Anencephaly / acrania	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.27. Encephalocele	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.28. Spina bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
SIF.29. Holoprosencephaly/arhinencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.30. Structural eye abnormalities/dysplasia	<input type="checkbox"/> No <input type="checkbox"/> Yes	
SIF.31. Arthrogryposis	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.32. Clubfoot	<input type="checkbox"/> No <input type="checkbox"/> Yes	
SIF.33. Hydrops	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.34. Ascites	<input type="checkbox"/> No <input type="checkbox"/> Yes	
SIF.35. Other	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:			
SIF.36. Description of abnormal ultrasound findings:				



U.S. Zika Pregnancy Registry and Birth Defects Surveillance – Integrated Supplemental Maternal Prenatal Imaging and Diagnostics Form

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SIF.37. Date(s) of Ultrasound(s): <input type="checkbox"/> SIF.38. check if date approximated SIF.39. if date not known, gestational age _____ (weeks) (days)	SIF.40. Overall fetal ultrasound results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
	SIF.41. <input type="checkbox"/> Reported by patient/healthcare provider SIF.42. <input type="checkbox"/> Ultrasound report			
	SIF.43. Head Circumference (HC) _____ cm SIF.44. <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (<i>by physician report</i>)			
	SIF.45. Biparietal diameter (BPD) _____ cm SIF.46. Femur length (FL) _____ cm SIF.47. Abdominal circumference (AC) _____ cm			
	SIF.48. <input type="checkbox"/> Symmetric IUGR <input type="checkbox"/> Asymmetric IUGR (HC>AC or HC>FL)			
	SIF.49. Microcephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.50. Intracranial calcifications	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.51. Cerebral / cortical atrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.52. Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.53. Corpus callosum abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.54. Cerebellar abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.55. Porencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.56. Hydranencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.57. Moderate or severe ventriculomegaly/hydrocephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.58. Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.59. Other major brain abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.60. Anencephaly / acrania	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.61. Encephalocele	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.62. Spina bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.63. Holoprosencephaly/arhinencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.64. Structural eye abnormalities/dysplasia	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.65. Arthrogyposis	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.66. Clubfoot	<input type="checkbox"/> No <input type="checkbox"/> Yes
SIF.67. Hydrops	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.68. Ascites	<input type="checkbox"/> No <input type="checkbox"/> Yes	
SIF.69. Other	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:			

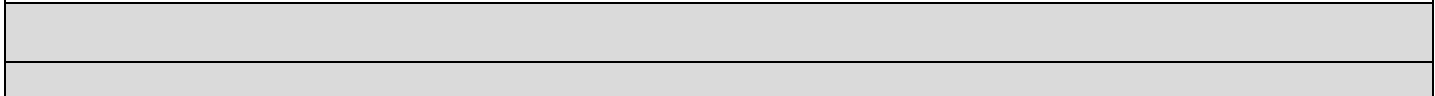
SIF.70. Description of abnormal ultrasound findings:

Health Department Information

SIF.71. Name of person completing form: _____

SIF.72. Phone: _____ **SIF.73. Email:** _____

SIF.74. Date form completed _____



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).