DALLAS COUNTY HEALTH AND HUMAN SERVICES
Epidemiology

Registry ID _____

ZIKA PREGNANCY SURVEILLANCE FORM: NEONATE ASSESSMENT AT DELIVERY

These data are considered confidential and will be stored in a secure database at the Centers for Disease Control and Prevention and Dallas County Health and Human Services

Please return completed form by sending an encrypted email to Epidemiology@dallascounty.org or by secure fax to: (214) 819-1933. For assistance with completing these forms, contact DCHHS at (214) 235-1799 or CDC at (770) 488-7100

Neonate Assessment

Infant's name: _____
Last First MI

Mother's name: _____
Last First MI

NAD.1. Infant's State/Territory ID _____

NAD.2. Mother's State/Territory ID _____

NAD.3. DOB: _____/_____/_____
☐Live birth
☐Stillbirth

NAD.4. Sex:
☐ Male ☐ Female
☐ Ambiguous/undetermined

NAD.5. Gestational age at delivery:
_____ weeks _____ days

NAD.6. Based on: (*check all that apply*)
☐ LMP ___/___/___ ☐ U/S (1st trimester)
☐ U/S (2nd trimester) ☐ U/S (3rd trimester)
☐ Other_____

NAD.7. State/Territory reporting: _____

NAD.8. County reporting: _____

NAD.9. Delivery type: ☐Vaginal ☐Caesarean section

NAD.10. Delivery complication: ☐ No ☐ Yes

NAD.11. If yes, please describe: _____
_____

NAD.12. Arterial Cord blood pH (*if performed*): _____

NAD.13. Venous Cord blood pH (*if performed*): _____

NAD.14. Placental exam (based on path report): ☐ No ☐ Yes

NAD.15. If yes, ☐ Normal ☐ Abruption ☐ Inflammation ☐ Other abnormality (*please describe*)

NAD.16. Apgar score: 1 min _____ / 5 min _____

NAD.17. Infant temp (*if abnormal*): ___°F **or** ___°C

Physical Examination

NAD.18. Birth head circumference: ____☐ cm _____☐ in

NAD.19. ☐ molding present

NAD.20. Physican report: ☐ Normal ☐ Abnormal

NAD.21. Birth weight:
_____☐ grams
_____☐ lbs/oz

NAD.22. Birth length:
_____ ☐ cm
_____ ☐ in

NAD.23. *Repeat* head circumference:
_____☐ cm _____☐ in
☐ <24hrs ☐ 24–35hrs ☐ 36–48hrs ☐ >48hrs

NAD.24. Physican report: ☐ Normal ☐ Abnormal

NAD.25. Admitted to Neonatal Intensive Care Unit:
☐ No ☐ Yes *If yes,* reason: _____

NAD.26. Neonatal death: ☐ No ☐ Yes
Date __/__/____ *or* age at death_____ days

NAD.27. Microcephaly (head circumference <3%ile):
☐ No ☐ Yes

NAD.28. Seizure: ☐ No ☐ Yes

NAD.29. Neurologic exam: (*check all that apply*)
☐ Not performed ☐ Unknown ☐ Normal ☐ Hypertonia/Spasticity ☐ Hyperreflexia ☐ Irritability
☐ Tremors ☐ Other neurologic abnormalities

NAD.30. (*please describe below*)

Infant's State ID _____ Registry ID _____
Mother's State ID _____

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NAD.31. Splenomegaly *by physical exam*: ☐ No ☐ Yes ☐ Unknown **NAD.32.** (*please describe*)	**NAD.33. Hepatomegaly** *by physical exam*: ☐ No ☐ Yes ☐ Unknown **NAD.34.** (*please describe*)	**NAD.35. Skin rash** *by physical exam:* ☐ No ☐ Yes ☐ Unknown **NAD.36.** (*please describe*)

NAD.37. Other abnormalities identified: *please check all that apply*

☐ Microphthalmia ☐ Absent red reflex ☐ Excessive and redundant scalp skin
☐ Arthrogryposis (congenital joint contractures) ☐ Congenital Talipes Equinovarus (clubfoot)
☐ Other abnormalities **NAD.38.** (*please describe below*)

Neonate Imaging and Diagnostics

NAD.39. Hearing screening : *(date:____/_____/_____)*

NAD.40. ☐ Pass ☐ Fail or referred ☐ Not performed **NAD.41.** *(please describe below)*

NAD.42. Retinal exam (with dilation): ☐ Not Performed ☐ Performed ☐ Unknown

NAD.43. *If performed: (date: _____/_____/_____)*

NAD.44. *please check all that apply:*

☐ Microphthalmia ☐ Chorioretinitis ☐ Macular pallor ☐ Other retinal abnormalities

NAD.45. (*please describe below)*

NAD.46. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Not Performed

NAD.47. *(date: _____/_____/_____)*

NAD.48. Findings: *check all that apply*

☐ Encephalocele ☐ Microcephaly ☐ Cerebral (brain) atrophy ☐ Cerebellar abnormalities
☐ Intracranial calcification ☐ Ventricular enlargement ☐ Lissencephaly ☐ Pachygyria
☐ Hydranencephaly ☐ Porencephaly ☐ Abnormality of corpus callosum
☐ Other abnormalities **NAD.49.** (*please describe below*)

NAD.50. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Not Performed

NAD.51. *(date: _____/_____/_____)*

NAD.52. Findings: *check all that apply*

☐ Encephalocele ☐ Microcephaly ☐ Cerebral (brain) atrophy ☐ Cerebellar abnormalities
☐ Intracranial calcification ☐ Ventricular enlargement ☐ Lissencephaly ☐ Pachygyria
☐ Hydranencephaly ☐ Porencephaly ☐ Abnormality of corpus callosum
☐ Other abnormalities **NAD.53.** (*please describe below*)

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NAD.54. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT

NAD.55. *(date: _____/_____/_____)* ☐ Not Performed

NAD.56. Findings: *check all that apply*

☐ Encephalocele ☐ Microcephaly ☐ Cerebral (brain) atrophy ☐ Cerebellar abnormalities
☐ Intracranial calcification ☐ Ventricular enlargement ☐ Lissencephaly ☐ Pachygyria
☐ Hydranencephaly ☐ Porencephaly ☐ Abnormality of corpus callosum
☐ Other abnormalities **NAD.57.** (*please describe below*)

NAD.58. Was a lumbar puncture performed: ☐ Yes ☐ No ☐ Unknown **NAD.59.** *(date: _____/_____/_____)*

NAD.60.	Toxoplasmosis infection:	☐ Negative ☐ Positive ☐ Unknown
NAD.61.	Cytomegalovirus infection:	☐ Negative ☐ Positive ☐ Unknown
NAD.62.	Herpes Simplex infection:	☐ Negative ☐ Positive ☐ Unknown
NAD.63.	Rubella infection:	☐ Negative ☐ Positive ☐ Unknown
NAD.64.	Syphillis infection:	☐ Negative ☐ Positive ☐ Unknown

NAD.65. Other tests/results/diagnosis (*include dates*):

NAD.64.	Syphillis infection:	☐ Negative ☐ Positive ☐ Unknown

NAD.65. Other tests/results/diagnosis (*include dates*):

Health Provider Information

Provider name: ☐ Dr. ☐ PA ☐ RN ☐ Other (Last)_____ (First)_____

Hospital/Facility: _____Phone: _____ Email: _____

Name of person completing form (if different from provider): _____ Date of form completion:____/____/____

Health Department Information

Name of person completing form: _____

Phone: _____ **Email:** _____ **Date of form completion**_____/_____/____

FOR INTERNAL CDC USE ONLY
Mother ID: **State/territory ID:**