DALLAS COUNTY HEALTH AND HUMAN SERVICES
Epidemiology

Registry ID _____

ZIKA PREGNANCY SURVEILLANCE FORM: INFANT HEALTH FOLLOW-UP

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) 4887100

Infant follow up: ☐ 2 months ☐ 6 months ☐ 12 months

Infant's name:	**Mother's name:**
_____	_____
Last First MI	Last First MI

IFU.1. State reporting _____ **IFU.2.** Date of infant examination _____/_____/____

IFU.3. Infant's State ID	**IFU.4.** Mother's State ID	**IFU.5.** DOB:	**IFU.6.** Sex: ☐ Male ☐ Female ☐ Ambiguous/undetermined
_____	_____	____/_____/_____	

IFU.7. Infant Death: ☐ No ☐ Yes, date _____/_____/____ or Age at death _____ ☐ Unknown

IFU.8. Weight:	**IFU.9.** Length:	**IFU.10.** Head circumference:
_____grams **or** ____ lbs_____ oz	_____ cm **or** _____ in	_____ cm **or** _____ in

IFU.11. Infant findings for corrected age at examination: (*For infants born preterm, please account for corrected age: chronological age minus weeks born before 40 weeks' gestation)*

Check all that apply

☐ Microcephaly (head circumference <3%ile) ☐ Excessive and redundant scalp skin
☐ Arthrogryposis (congenital joint contractures) ☐ Congenital Talipes Equinovarus (clubfoot)
☐ Hypertonia/Spasticity ☐ Hyperreflexia ☐ Irritability ☐ Tremors
☐ Splenomegaly ☐ Hepatomegaly ☐ Skin rash ☐ Microphthalmia
☐ Absent red reflex ☐ Swallowing/feeding difficulties ☐ Other

IFU.12. *Please list other abnormal findings:*

IFU.13. Development assessment for corrected age at examination: (*For infants born preterm, please account for corrected age: chronological age minus weeks born before 40 weeks' gestation)*
☐ Normal ☐ Abnormal ☐ Unknown

IFU.14. If developmental delay, in what area? *Please check all that apply*
☐ Gross motor ☐ Fine motor ☐ Cognitive, linguistic and communication ☐ Socio-Emotional

Special Studies Since Last Follow-up

IFU.15. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Other _____
☐ Not Performed ☐ Unknown **IFU.16.** Date: _____/_____/_____

IFU.17. Findings: *check all that apply*
☐ Microcephaly ☐ Cerebral (brain) atrophy ☐ Cerebellar atrophy ☐ Intracranial calcification
☐ Ventricular enlargement ☐ Lissencephaly ☐ Pachygyria ☐ Hydranencephaly
☐ Porencephaly ☐ Abnormality of corpus callosum ☐ Other abnormalities

IFU.18. *Please describe below*

IFU.19. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Other _____
☐ Not Performed ☐ Unknown **IFU.20.** Date: _____/_____/_____

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

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IFU.21. Findings: *check all that apply*

☐ Microcephaly ☐ Cerebral (brain) atrophy ☐ Cerebellar atrophy ☐ Intracranial calcification
☐ Ventricular enlargement ☐ Lissencephaly ☐ Pachygyria ☐ Hydranencephaly
☐ Porencephaly ☐ Abnormality of corpus callosum ☐ Other abnormalities

IFU.22. (*please describe below*)

IFU.23. Hearing screening or re-screening: ☐ Not performed ☐ Performed ☐ Unknown
IFU.24. *If performed:* Date: ____/____/____ **IFU.25.** ☐ Pass ☐ Fail or referred,
IFU.26. *Please describe*

IFU.27. Audiological evaluation: ☐ Not performed ☐ Performed ☐ Unknown
IFU.28. *If performed:* Date: ____/____/____ **IFU.29.** ☐ Normal ☐ Abnormal,
IFU.30. *Please describe*

IFU.31. Retinal exam (with dilation): ☐ Not Performed ☐ Performed ☐ Unknown
IFU.32. *If performed:* Date: _____/_____/_____
IFU.33. Findings: *Check all that apply:*
☐ Microphthalmia ☐ Chorioretinitis ☐ Macular pallor ☐ Other retinal abnormalities
IFU.34. *Please describe*

IFU.35. Other abnormal tests/results/diagnosis (include dates): ☐ No ☐ Yes
IFU.36. Date: _____/_____/_____
IFU.37. *Please describe*

Healthcare 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

IFU.38. Name of person completing form: _____ **IFU.39.** Phone: _____
IFU.40. Email: _____ **IFU.41.** Date of form completion___/____/____

Internal use only

Date entered____/_____/_____ ***Data Entry POC Initials:*** _____	***Data Entry Notes*:**