DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Pregnancy and Zika Virus Disease Surveillance Form

These data are considered confidential and will be stored in a secure database at the Centers for Disease Control and Prevention and the Delaware Division of Public Health (DPH).

Return completed form by email to reportdisease@state.de.us or by fax to the secure number: 302-223-1540.

For assistance with completing these forms, contact DPH at 888-295-5156.

Mother's Zika virus infection (ADB follow-up)

State/Territory ID:	**Maternal Age at Diagnosis:**	**State or Territory of Residence**

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race *(check all that apply)*: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or other Pacific Islander ☐ White or Caucasian

Indication for maternal Zika virus testing: ☐ Exposure history, no known fetal concerns ☐ Exposure history and fetal concerns

Date of Zika virus symptom onset: ___/___/___ **OR** ☐ Asymptomatic

If date not known, trimester of symptom onset _____

Hospitalized for Zika virus disease ☐ No ☐ Yes Maternal Death ☐ No ☐ Yes

Symptoms of mother's Zika virus disease: (check all that apply)

☐ Fever ____ degrees F (*if measured*) ☐ Rash ☐ Arthralgia ☐ Conjunctivitis

☐ Other Clinical Presentation_____

If symptomatic, gestational age at onset: _____weeks If gestational age not known ,trimester of symptom onset _____	**Travel history:** ☐ No ☐ Yes

Was Zika virus infection acquired in place of residence? ☐ No ☐ 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)? *Check all that apply.* ☐ Male ☐ Female

Did any male sexual partner(s) travel on this trip? ☐ No ☐ Yes ☐ Unknown

If yes, did any male partner(s) have an illness that included fever, rash, arthralgia, or conjunctivitis during or within two weeks of travel? ☐ No ☐ Yes ☐ Unknown

If yes, was there unprotected sexual contact while male partner(s) had illness?

☐ No ☐ Yes ☐ Unknown

If male partner(s) traveled, did he have a test that showed lab evidence of Zika?

☐ No ☐ Yes ☐ Unknown

Country(s) of exposure (2)_____	**Travel start ___/_____/_____**	**Travel end___/____/_____**

Mother's sexual partner(s)? *Check all that apply.* ☐ Male ☐ Female

Did any male sexual partner(s) travel on this trip? ☐ No ☐ Yes ☐ 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? ☐ No ☐ Yes ☐ Unknown

If yes, was there unprotected sexual contact while male partner(s) had illness?

☐ No ☐ Yes ☐ Unknown

If male partner(s) traveled, did he have a test that showed lab evidence of Zika?

☐ No ☐ Yes ☐ Unknown

Country(s) of exposure (3) _____	**Travel start** __/__/____	**Travel end** __/__/____

Mother's sexual partner(s)? *Check all that apply.* ☐ Male ☐ Female

Did any male sexual partner(s) travel on this trip? ☐ No ☐ Yes ☐ 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? ☐ No ☐ Yes ☐ Unknown

If yes, was there unprotected sexual contact while male partner(s) had illness? ☐ No ☐ Yes ☐ Unknown

If male partner(s) traveled, did he have a test that showed lab evidence of Zika? ☐ No ☐ Yes ☐ Unknown

NON-TRAVELLING WOMAN: other possible exposures?

☐ Sexual partner w/travel history, symptomatic, lab evidence of Zika
☐ Sexual partner w/travel history, symptomatic, no test results
☐ Sexual partner w/travel history, asymptomatic, lab evidence Zika
☐ Other, describe_____
☐ Unknown exposure history

Mother's pregnancy (DRH/DBDDD follow-up)

Last menstrual period (LMP): __/__/____ **Estimated delivery date:** __/__/____

Estimated delivery date based on (*check all that apply*):
☐ LMP __/__/__ ☐ U/S (First trimester) ☐ U/S (Second trimester) ☐ U/S (Third trimester)

History: # pregnancies ____ # living children ____ # miscarriages ____ # elective terminations ____

Prior fetus/infant with microcephaly: ☐ No ☐ Yes **If yes, genetic cause:** ☐ No ☐ Yes

Gestation: ☐ Single ☐ Twins ☐ Triplets+

Underlying maternal illness:
Diabetes ☐ No ☐ Yes Maternal PKU ☐ No ☐ Yes
Hypothyroidism ☐ No ☐ Yes Hypertension ☐ No ☐ Yes
Substance use during this pregnancy: Alcohol use ☐ No ☐ Yes Cocaine use ☐ No ☐ Yes Smoking ☐

Complications of pregnancy:
Toxoplasmosis ☐ Negative ☐ Positive ☐ Unknown
Cytomegalovirus ☐ Negative ☐ Positive ☐ Unknown
Herpes Simplex ☐ Negative ☐ Positive ☐ Unknown
Rubella ☐ Negative ☐ Positive ☐ Unknown
Syphilis ☐ Negative ☐ Positive ☐ Unknown
Fetal genetic abnormality ☐ No ☐ Yes, *diagnosis* _____ ☐Unknown
Gestational diabetes ☐ No ☐ Yes Pregnancy-related HTN ☐ No ☐ Yes
Intrauterine death of a twin ☐ No ☐ Yes
Other _____

Medications during pregnancy: ☐ No ☐ Yes (*List type and see guide for further instructions)*

Did this pregnancy end in miscarriage or intrauterine fetal demise (IUFD)? ☐ No ☐ Yes Date: ___/____/____ Gestational age_____weeks	**Was this pregnancy terminated?** ☐ No ☐ Yes Date: ___/____/ Gestational age_____weeks

Maternal Prenatal Imaging and Diagnostics

Date(s) of Ultrasound(s):	
	Overall Fetal Ultrasound Results: ☐ Normal ☐ Abnormal

___/___/____ ☐ check if date Is approximate if date not known, gestational age _____ weeks	☐ reported by patient/healthcare provider ☐ ultrasound report Head Circumference ____cm ☐ Normal ☐ Abnormal (*by physician report*) Biparietal diameter ____cm Femur Length ___cm Abdominal circumference _____cm ☐ Symmetrical intrauterine growth restriction (IUGR) (<5% EFW)
	Intracranial calcifications ☐ No ☐ Yes Ventriculomegaly ☐ No ☐ Yes
	Cerebral atrophy ☐ No ☐ Yes Ocular anomalies ☐ No ☐ Yes
	Cerebellar abnormalities ☐ No ☐ Yes Arthrogryposis ☐ No ☐ Yes
	Lissencephaly ☐ No ☐ Yes Pachygyria ☐ No ☐ Yes Hydranencephaly ☐ No ☐ Yes Porencephaly ☐ No ☐ Yes Corpus callosum abnormalities ☐ No ☐ Yes Hydrops ☐ No ☐ Yes
	Ascites ☐ No ☐ Yes Other ☐ No ☐ Yes, describe

Description of abnormal ultrasound findings:

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

Description of abnormal ultrasound findings:

___/___/___
☐ Check if date is approximate

if date not known, gestational age _____ weeks

Overall Fetal Ultrasound Results: ☐ Normal ☐ Abnormal
☐ reported by patient/healthcare provider ☐ ultrasound report

Head Circumference ___ cm ☐ Normal ☐ Abnormal (by physician report)
Biparietal diameter _____ cm
Femur Length _____cm Abdominal circumference _____ cm

Intracranial calcifications ☐ No ☐ Yes Ventriculomegaly ☐ No ☐ Yes

Cerebral atrophy ☐ No ☐ Yes Ocular anomalies ☐ No ☐ Yes

Cerebellar abnormalities ☐ No ☐ Yes Arthrogryposis ☐ No ☐ Yes

Lissencephaly ☐ No ☐ Yes Pachygyria ☐ No ☐ Yes
Hydranencephaly ☐ No ☐ Yes Porencephaly ☐ No ☐ Yes
Corpus callosum abnormalities ☐ No ☐ Yes Hydrops ☐ No ☐ Yes

Ascites ☐ No ☐ Yes Other ☐ No ☐ Yes, describe

Description of abnormal ultrasound findings:

For additional ultrasounds, request a supplementary ultrasound form.

Fetal MRI performed: ☐ No ☐ Yes (A*nswer questions below*)

___/___/___
☐ Check if date is approximate

if date not known, gestational age _____ weeks

Overall Fetal MRI Results: ☐ Normal ☐ Abnormal
☐ reported by patient/healthcare provider ☐ ultrasound report

Head Circumference _cm ☐ Normal ☐ Abnormal (by physician report)
Biparietal diameter _____cm
Femur Length _____cm Abdominal circumference
_____cm
☐ Symmetrical IUGR (<5% EFW) ☐ Asymmetrical IUGR (HC<FL or HC <AC)

Intracranial calcifications ☐ No ☐ Yes Ventriculomegaly ☐ No ☐ Yes

Cerebral atrophy ☐ No ☐ Yes Ocular anomalies ☐ No ☐ Yes

Cerebellar abnormalities ☐ No ☐ Yes Arthrogryposis ☐ No ☐ Yes

Lissencephaly ☐ No ☐ Yes Pachygyria ☐ No ☐ Yes
Hydranencephaly ☐ No ☐ Yes Porencephaly ☐ No ☐ Yes
Corpus callosum abnormalities ☐ No ☐ Yes Hydrops ☐ No ☐ Yes

Ascites ☐ No ☐ Yes Other ☐ No ☐ 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 Describe:

Provider Information

Provider name: ☐ Dr. ☐ PA ☐ RN ☐ Mr. ☐ Ms.

_____
Last First MI

Phone: _____ Email**:** _____

Date of form completion _____/_____/

Name of person completing form: (if different from provider)

_____
Last First MI

Hospital/facility**:** _____

Phone: _____ Email:

Date of form completion _____**/**_____**/**

Health Department Information

Name of person completing form: _____

Phone: _____ **Email:** _____

Date of Form Completion: _____**/**_____**/**_____