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 at 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 completion of these forms, contact DPH at 888-295-5156.

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

Date of infant examination
____/_____/_____

Infant's State/Territory ID	**Mother's State/Territory ID**	**DOB:** ____/_____/_____	**Sex:** ☐ Male ☐ Female ☐ Ambiguous/undetermined

Infant Death: ☐ No ☐ Yes, date ____/_____/____ ☐ Unknown

Weight: _____ ☐ grams _____ ☐ lbs/oz	**Length:** _____ ☐ cm _____ ☐ in	**Head circumference** _____ ☐ cm _____ ☐ in

Infant findings for corrected age at examination: (For infants born preterm, account for corrected age: chronological age minus weeks born before 40 weeks gestation)

Check all that apply:

☐ Microcephaly (head circumference < 3 percentile) ☐ 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 ☐ Excessive and redundant scalp skin ☐ Swallowing/feeding difficulties
☐ Congenital Talipes Equinovarus (clubfoot) ☐ Arthrogryposis (congenital joint contractures)

List other abnormal findings:

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

If developmental delay, in what area? Check all that apply.
☐ Gross motor ☐ Fine motor ☐ Cognitive, linguistic and communication ☐ Socio-Emotional

Special Studies Since Last Follow-Up

Imaging study: ☐ Cranial ultrasound (date: ____/_____/_____) ☐ MRI (date: _____/_____/_____)
☐ CT (date: _____/_____/_____) ☐ Other _____ ☐ Not Performed

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

Imaging study: ☐ Cranial ultrasound (date: ____/_____/_____) ☐ MRI (date: _____/_____/_____)
☐ CT (date: _____/_____/_____) ☐ Other _____ ☐ Not Performed

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

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

Findings: Check all that apply.

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

Hearing screening or re-screening: ☐ Not performed ☐ Unknown
If performed: (date:____/____/____) ☐ Pass ☐ Fail or referred, *describe*

Audiological evaluation: ☐ Not performed ☐ Unknown
If performed: (date:____/____/____) ☐ Normal ☐ Abnormal, *describe*

Retinal exam (with dilation): ☐ Not Performed ☐ Unknown
If performed, check all that apply: (date: _____/_____/_____)
☐ Microphthalmia ☐ Chorioretinitis ☐ Macular pallor ☐ Other retinal abnormalities (*describe below)*

Other abnormal tests/results/diagnosis (include dates): ☐ No ☐ Yes (date: _____/_____/_____)
Describe:

Provider Information

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

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

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

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

Health Department Information

Name of person completing form: _____

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