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.

Neonate Assessment

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

Gestational age at delivery: _____ weeks _____ days

Based on: (*check all that apply*)
☐ LMP ___/___/___ ☐ U/S (First trimester)
☐ U/S (Second trimester) ☐ U/S (Third trimester)
☐ Other_____

State/Territory of residence: _____

County of residence: _____

Delivery type: ☐ Vaginal ☐ Caesarean section

Delivery complication: ☐ No ☐ Yes

If yes, _____

Arterial Cord blood pH (*if performed):* _____

Venous Cord blood pH (*if performed):* _____

Placental exam (based on path report): ☐ No ☐ Yes
If yes, ☐ Normal ☐ Abruption ☐ Inflammation ☐ Other abnormality (*describe*)

Apgar score: 1 min _____ / 5 min _____

Infant temp (*if abnormal*): _____ degrees F

Physical Examination

Birth head circumference: _____☐ cm
_____☐ in
☐ molding present
Physican report : ☐ Normal ☐ Abnormal

Birth weight:
_____☐ grams
_____☐ lbs/oz

Birth length:
_____ ☐ cm
_____ ☐ in

***Repeat* head circumference:**_____☐ cm _____☐ in
☐ < 24 hours ☐ 24-35 hours ☐ 36-48 hours ☐ > 48 hours
Physican report : ☐ Normal ☐ Abnormal

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

Microcephaly (head circumference <3 percentile):
☐ No ☐ Yes

Seizures: ☐ No ☐ Yes

Neurologic exam*: check all that apply* ☐ Not performed ☐ Unknown
☐ Normal ☐ Hypertonia/Spasticity ☐ Hyperreflexia ☐ Irritability
☐ Tremors ☐ Other Neurologic abnormalities (*describe below*)

Splenomegaly (*by physical exam*)**:**
☐ No ☐ Yes ☐ Unknown
(describe)

Hepatomegaly (*by physical exam*)**:**
☐ No ☐ Yes ☐ Unknown
(describe)

Skin rash (*by physical exam):*
☐ No ☐ Yes ☐ Unknown
(describe)

Other abnormalities identified: (provide clinical description from medical records and include chromosomal abnormalities and syndromes). *Check all that apply:*
☐ Microphthalmia ☐ Absent red reflex ☐ Excessive and redundant scalp skin
☐ Arthrogryposis (congenital joint contractures) ☐ Congenital Talipes Equinovarus (clubfoot)
☐ Other abnormalities (*describe below*)

Approved
OMB No. 0920-1101
Exp. 08/31/2016

Neonate Imaging and Diagnostics

Hearing screening: (date:____/_____/_____) ☐ Pass ☐ Fail or referred ☐ Not performed
(describe below)

Retinal exam (with dilation): ☐ Not Performed ☐ Unknown

If performed: (date: _____/_____/_____) *check all that apply:*

☐ Microphthalmia ☐ Chorioretinitis ☐ Macular pallor ☐ Other retinal abnormalities (*describe below)*

Imaging study: ☐ Cranial ultrasound (date: _____/_____/_____) ☐ MRI (date: _____/_____/_____)
☐ CT *(date: _____/_____/_____)* ☐ 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*)

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☐ Abnormality of corpus callosum ☐ Other abnormalities (*describe below*)

Was a lumbar puncture performed: ☐ Yes ☐ No ☐ Unknown (date: _____/_____/_____)

Congenital Infection Testing: *if performed, specify test (i.e. PCR, IgG, IgM)*

	Toxoplasmosis	Cytomegalovirus	Herpes Simplex	Rubella	Other
Positive					
Negative					
Not Done					
Date					

Other tests/results/diagnosis (*include dates*)**:**

Health Department Information

Name of person completing form:

_____

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