NJDOH Zika Delivery Packet

Updated December 17, 2021

The information in this packet is intended to streamline the process for evaluating and testing infants with possible congenital Zika virus infection. Use the NJDOH Zika Delivery Checklist for Birthing Hospitals to guide step-by-step actions. For information on NJDOH testing criteria and guidance, see the NJDOH Zika website. For additional assistance, the NJDOH Zika Team can be reached at: CDSVectorTeam@doh.nj.gov or 609-826-5964.

NJDOH Zika Delivery Checklist for Birthing Hospitals

☐ **Determine if mother had a possible Zika virus exposure during pregnancy. Screening tool: https://www.cdc.gov/pregnancy/documents/zika-patient-screening-p.pdf**

If YES: Continue with the steps listed below.
If NO: No further action required.

☐ **Assess if mother was tested for Zika virus.**

If YES: Obtain test results.
If NO: If mother meets criteria for Zika virus testing, collect serum and urine specimens.

☐ **Collect infant serum and urine specimens:**

- Infants with birth defects consistent with congenital Zika syndrome born to mothers with possible exposure to Zika virus during pregnancy (regardless of mother's Zika test results).
- Infants without birth defects consistent with congenital Zika syndrome who were born to mothers with laboratory evidence of possible Zika virus infection during pregnancy.
- Testing is not routinely recommended for infants without birth defects consistent with congenital Zika syndrome who were born to mothers without laboratory evidence of possible Zika virus infection during pregnancy. Further evaluation beyond the standard evaluation and preventive care is not routinely indicated unless abnormalities are noted at any time.

☐ **Save placental/cord tissue for Zika testing if**:

- Infants without Congenital Zika Syndrome:
  a. If live birth and the mother's test results indicate "Zika or flavivirus, infection cannot be determined" (IgM positive with inconclusive PRNTs) AND mother was symptomatic during pregnancy OR had ongoing exposure throughout pregnancy.
  b. Unless mother tested negative for Zika within 12 weeks of exposure, consider tissue testing for all fetal loss/infant death.

- Infants with Congenital Zika Syndrome:
  a. If live birth and the mother's test results indicate "Zika or flavivirus, infection cannot be determined" (IgM positive with inconclusive PRNTs).
  b. Unless mother tested negative for Zika within 12 weeks of exposure, consider tissue testing for all fetal loss/infant death.

☐ **To guide specimen collection, processing and shipping,** consult the "NJDOH Zika Delivery Specimen Collection Guidance" table (see page 3).

- **Request testing through the NJDOH.** For approval of testing, complete and return the NJDOH Zika Delivery Testing Form (MATERNAL) and NJDOH Zika Delivery Testing Form (Infant) forms to the NJDOH Zika Team by sending an encrypted e-mail to CDSVectorTeam@doh.nj.gov or faxing to 609-826-4874 [Phone: 609- 826-5964]. Once forms are reviewed and approved, NJDOH Vector Team will provide your laboratory with required specimen submission forms.

☐ **For infants either (1) with clinical findings consistent with Congenital Zika Syndrome or; (2) who are born to a mother with laboratory evidence of possible Zika virus infection during pregnancy, complete:**

1. The "CDC Zika Neonate Assessment Form" and return to NJDOH as directed at the top of the form, and;
2. The "CDC Zika Clinical Summary for Pediatric Healthcare Provider" and forward to the infant's outpatient pediatrician.

Zika Delivery Specimen Collection Guidance

LABEL ALL SPECIMENS WITH: Infant's full name, date of birth, date and time of collection, and type of specimen (FOR TISSUE, USE MOTHER'S NAME) FREEZE ALL SPECIMENS (except fixed-tissue) AT -70°C AND SHIP OVERNIGHT TO NJ PHEL ON DRY ICE AS A CATEGORY B INFECTIOUS SUBSTANCE – 49 CFR 173.199 (CATEGORY B) AND 49 CFR 173.217 (DRY ICE)

Serum from Infants and Mothers

Minimum Volume	Container	Storage	Additional Instructions
Collect enough blood to yield: Infant: 1.5-2.0 ml of serum Mother: 3.0 ml of serum	• Collect in serum separator tube (tiger top, speckle top, or gold top). • Promptly send to laboratory. • In lab: aspirate 1.5-2.0 ml of serum into a leak-proof, screw-capped tube. • UNACCEPTABLE: Blood in anticoagulant or plain red top tubes	• Freeze at -70 to -80° C and ship on dry ice. • EXCEPTION: store at 4° C only if specimens will be received at PHEL within 24 hours of collection.	For information on packaging and shipping refer to the Zika Technical Bulletins at: http://nj.gov/health/phel/index.shtml

Urine from Infants and Mothers

Minimum Volume	Container	Storage	Additional Instructions
Collect urine on same day as serum: • 3.0 ml of urine	• Collect in clean container. • Promptly send to laboratory. • In lab: transfer to clean, leak-proof screwcap tube. • UNACCEPTABLE: Urine in tube with preservative or submitted in urine cup	• Freeze at -70° to -80° C and ship on dry ice. • EXCEPTION: store at 4° C only if specimens will be received at PHEL within 24 hours of collection.	For information on packaging and shipping refer to the Zika Technical Bulletins at: http://nj.gov/health/phel/index.shtml.

Placenta, Cord, Membranes and/or Other Tissues

Fix specimens in 10% neutral buffered formalin and/or formalin fixed paraffin-embedded tissue blocks (FFPE)

Requirements	Container/Preservatives	Storage	Additional Instructions
Placenta and fetal membranes: • At least 3 full thickness pieces (0.5–1 cm x 3–4 cm) from the middle third of placental disk and at least 1 piece from the placental disk margin. • 5 x 12 cm strip of fetal membranes. • Include sections of the placental disk, fetal membranes, and pathologic lesions when possible. **Umbilical cord:** • 4 or more 2.5 cm segments of cord tissues. • Umbilical cord segments should be obtained proximal, middle, and distal to umbilical cord insertion site on the placenta.	• Tissues should be placed into one or more containers containing adequate formalin. • Volume of formalin used should be about 10x mass of tissue. • Label all specimens to identify location of sample.	• Fixed tissues should be stored and shipped at room temperature. (Please use cold packs in the shipment). • Tissue can be fixed in formalin for 3 days, and then transferred to 70% ethanol for shipping purposes or for long term storage at ambient temperature.	• Tissue testing must be pre-approved by NJDOH during business hours. Please process tissue according to these instructions if awaiting approval. • Include information about placenta weight and sample both maternal and fetal side of the placenta. • SHIP TO NJ PHEL AS AN "EXEMPT HUMAN SPECIMEN" IF FIXATIVE VOLUME IS LESS THAN 30ml. • IF OVER 30 ml OF FIXATIVE IS USED, CONTACT zika.phel@doh.nj.gov for shipping instructions. • Fixed tissue sample should not be shipped with frozen samples. • Use cold packs to prevent overheating of these specimens during shipment throughout the summer months.

NJDOH ZIKA DELIVERY TESTING FORM (MATERNAL)

To request Zika Virus testing at the NJ Public Health and Environmental Laboratory (PHEL) for pregnant women who present for delivery and meet current Zika testing criteria, complete this form and send to the NJDOH Zika Team by encrypted email: CDSVectorTeam@doh.nj.gov **or fax to 609-826-4874.**

NJDOH Zika Testing and Management Recommendations for Pregnant Women: https://nj.gov/health/cd/topics/zika.shtml
CDC's Zika Travel Information page: https://wwwnc.cdc.gov/travel/page/zika-information

Demographics

Patient Last Name **First Name**	**DOB:** ____ / ____ / ____	**Phone number**
Address	**City**	**Municipality**

Race
☐ White ☐ American Indian/Alaskan Native ☐ Other/Unknown
☐ Black ☐ Asian/Pacific Islander

Ethnicity
☐ Hispanic
☐ Non-Hispanic
☐ Unknown

Physician and Facility Information

Physician who is ordering the Zika virus test

Name: _____
Address: _____
Phone:_____ Fax: _____
Email: _____

Facility

Name of facility: _____
Date of admission: ___ /___ /_____
Date of discharge: ___ /___ /_____

Clinical Status

Patient's symptom status: ☐ Currently symptomatic ☐ Previously symptomatic ☐ Asymptomatic*

**Asymptomatic persons do not meet NJDOH testing criteria unless fetal/infant abnormalities are detected, in cases of fetal loss/infant death, or other extenuating circumstance*

Sign/Symptom	Response	Onset	Resolution	Additional required information
Fever	☐ Yes ☐ No ☐ Unk.	___ /___ /_____	___ /___ /_____	Tmax:
Rash	☐ Yes ☐ No ☐ Unk	___ /___ /_____	___ /___ /_____	
Conjunctivitis	☐ Yes ☐ No ☐ Unk	___ /___ /_____	___ /___/_____	
Arthralgia	☐ Yes ☐ No ☐ Unk	___ /___ /_____	___ /___/_____	
Neurological symptoms	☐ Yes ☐ No ☐ Unk	___ /___ /_____	___ /___/_____	Describe:

Additional symptoms (e.g., headache, myalgia, eye pain, etc.)**:**

Did the patient receive the following vaccinations? If yes, indicate the year of immunization if known.

☐ Yellow Fever Date: _____ ☐ Japanese Encephalitis Date: _____ ☐ Tickborne Encephalitis Date: _____

Previous history (year) of flavivirus/arboviral disease: ☐ West Nile Virus Year: _____ ☐Previous Zika diagnosis (mm/yy): _____
☐Chikungunya Year: _____ ☐ Dengue Year: _____ ☐Powassan Year: _____ ☐Other:_____ Year: _____

Was patient tested for Dengue? ☐ Yes ☐ No ☐ Unk **Results:** _____

Risk factors

Did patient travel to areas with active dengue transmission and a risk of Zika?
☐ Yes ☐ No ☐ Unk

Travel locations:_____
Date of arrival: _____ Date of departure: _____

Did patient have unprotected sexual contact with Zika exposed partner?
☐ Yes ☐ No ☐ Unk

Date(s) of first and last unprotected sexual contact with Zika exposed partner: _____
Sexual partner's travel location(s): _____
Date of arrival: _____ Date of departure: _____

If patient had a different Zika virus exposure, specify: ☐ Congenital/Perinatal ☐ Laboratory/Healthcare ☐ Blood transfusion
☐ Organ recipient ☐ Other exposure, specify:_____

Additional Notes

NJDOH ZIKA DELIVERY TESTING FORM (INFANT)

1. **Complete this form and send to NJDOH by encrypted e-mail to**: CDSVectorTeam@doh.nj.gov or fax to 609-826-4874.
2. **Collect specimens as indicated in the Zika Delivery Checklist and according to the NJDOH specimen collection guidance provided in the Zika Delivery Packet.**
3. **NJDOH will provide the birthing hospital laboratory with the required authorization form for shipping to NJDOH.**

Infant Information

Infant Name - as it appears on hospital records (Last name, First name)	Date of Birth ___/___/ _____	Patient ☐ Male ☐ Female
Infant Home Address / City / State / Zip Code		Home Telephone Number

Race
☐ White ☐ American Indian/Alaskan Native ☐ Other/Unknown
☐ Black ☐ Asian/Pacific Islander

Ethnicity
☐ Hispanic
☐ Non-Hispanic
☐ Unknown

Maternal Information

Mother's Name (Last name, First name)	Date of Birth _____/_____/ _____

Birth Information

Gestational age: ____weeks_____days	Delivery type: ☐ Vaginal ☐ C-section	Delivery complications: ☐ Yes ☐ No
Birth head circumference _____cm Birth weight _____grams Birth length _____cm	Microcephaly ☐ No ☐ Yes Other abnormities ☐ No ☐ Yes, describe: _____	

Healthcare Provider Ordering the Zika Test

Name of Health Care Provider		Patient Medical Record # / ID #
Institution Name	Address	
Phone	Fax (to receive test results)	E-mail Address:

Birthing Hospital Contact Information

Primary Zika Contact for Birthing Hospital:	Phone:	Fax:	E-mail:
Infection Preventionist:	Phone:	Fax:	E-mail:
Nursery Where Infant is an Inpatient:	Phone:	Fax:	E-mail:
Laboratory Contact for Zika Specimen Send out:	Phone:	Fax:	E-mail:
Laboratory Contact for Pathology (placental tissue):	Phone:	Fax:	E-mail:

U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Neonate Assessment Form

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

Please return completed form to NJ Department of Health Zika Team by encrypted e-mail at: CDSVectorTeam@doh.nj.gov or by faxing to 609 826-4874 [Phone: 609-826-5964]

Infant Name: _____, _____ **Delivery Hospital:** _____

NAD.1. Infant's State/Territory ID _____	**NAD.2. Mother's State/Territory ID** _____	**NAD.3. DOB:** _____ ☐ Live birth ☐ Stillbirth ≥20 weeks	**NAD.4. Sex:** ☐ Male ☐ Female ☐ Ambiguous/undetermined
NAD.5. Gestational age at delivery: _____ weeks _____ days	**NAD.6. Based on**: (*check all that apply*) ☐ LMP Date:_____ ☐ 1st trimester ultrasound ☐ 2nd trimester ultrasound ☐ 3rd trimester ultrasound ☐ Other_____		**NAD.7. Maternal age at delivery**_____years

NAD.8. State/Territory reporting: _____ **NAD.9. County reporting:** _____

NAD.10. Delivery type:
☐ Vaginal ☐ Caesarean section

NAD.11. Delivery complication: ☐ No ☐ Yes

NAD.12. If yes, please describe:

NAD.13. Arterial cord blood pH (*if performed*): _____

NAD.14. Venous cord blood pH (*if performed*): _____

NAD.15. Placental exam (based on path report): ☐ No ☐ Yes

NAD.16. If yes, ☐ Normal ☐ Abruption ☐ Inflammation ☐ Other abnormality (*please describe*)

NAD.17. Apgar score:
1 min_____/ 5 min _____

NAD.18. Infant temp (*if abnormal*):_____°F **or**_____°C

Physical Examination (record earliest measurements taken)

NAD.19. Birth head circumference:
_____☐ cm_____☐ in

NAD.20. ☐ Molding present

NAD.21. Physician report: ☐ Normal ☐ Abnormal

NAD.22. HC percentile:_____

NAD.23. Birth weight:
_____☐ grams
_____☐ lbs/oz

NAD.24. Birth weight percentile: _____

NAD.25. Birth length:
_____ ☐ cm
_____ ☐ in

NAD.26. Birth length percentile:_____

NAD.27. *Repeat* head circumference:
_____☐ cm_____☐ in

NAD.28. Date performed:_____*or*
Age_____day(s)

NAD.29. Physician report: ☐ Normal ☐ Abnormal

NAD.30. HC percentile:_____

NAD.31. Admitted to Neonatal Intensive Care Unit:
☐ No ☐ Yes *If yes,* reason:
_____

NAD.32. Neonatal death: ☐ No ☐ Yes

NAD.33. Date:_____*or* Age at death_____days

NAD.34. Cause of death: _____

NAD.35. Microcephaly (head circumference <3%ile):
☐ No ☐ Yes

NAD.36. Seizures:
☐ No ☐ Yes

NAD.37. Neurologic exam: (*check all that apply*)
☐ Not performed ☐ Unknown ☐ Normal ☐ Hypertonia/Spasticity ☐ Hyperreflexia ☐ Irritability
☐ Tremors ☐ Other neurologic abnormalities **NAD.38.** (*please describe below*)

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

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NAD.39. Splenomegaly *by physical exam*: ☐ No ☐ Yes ☐ Unknown **NAD.40.** (*please describe*)	**NAD.41. Hepatomegaly** *by physical exam*: ☐ No ☐ Yes ☐ Unknown **NAD.42.** (*please describe*)	**NAD.43. Skin rash** *by physical exam:* ☐ No ☐ Yes ☐ Unknown **NAD.44.** (*please describe*)

NAD.45. Other abnormalities identified: *please check all that apply*

☐ Fetal Brain Disruption Sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)
☐ Encephalocele ☐ Anencephaly/ Acrania ☐ Spina bifida ☐ Holoprosencephaly/arhinencephaly
☐ Microphthalmia/Anophthalmia ☐ Arthrogryposis (congenital joint contractures)
☐ Congenital Talipes Equinovarus (clubfoot) ☐ Congenital hip dislocation/developmental dysplasia of the hip
☐ Other abnormalities

NAD.46. (*please describe below*)

Neonate Imaging and Diagnostics

NAD.47. Hearing screening : (Date:_____) *or* Age_____day(s)

NAD.48. ☐ Pass ☐ Fail ☐ Inconclusive/Needs retest ☐ Not performed

NAD.49. Please describe

NAD.50. Audiological evaluation: ☐ Not performed ☐ Auditory brainstem response (ABR) test performed
☐ Otoacoustic emissions (OAE) test performed ☐ Acoustic stapedius reflex (ASR) test performed
☐ Unknown

NAD.51. If performed: Date:_____ **NAD.52.** ☐ Normal ☐ Abnormal

NAD.53. Please describe

NAD.54. Retinal exam (with dilation): ☐ Not Performed ☐ Performed ☐ Unknown

NAD.55. *If performed:* (Date:_____) *or* Age_____day(s)

NAD.56. *please check all that apply:* ☐ Normal

☐ Microphthalmia/Anophthalmia ☐ Coloboma ☐ Cataract ☐ Intraocular calcifications

☐ Chorioretinal atrophy, scarring, macular pallor, gross pigmentary mottling, or retinal hemorrhage, excluding retinopathy of prematurity ☐ Other retinal abnormalities

☐ Optic nerve atrophy, pallor ☐ Other optic nerve abnormalities

NAD.57. (*please describe below)*

NAD.58. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Not Performed

NAD.59. (Date:_____) *or* Age_____day(s)

NAD.60. Findings: *check all that apply* ☐ Normal

☐ Microcephaly ☐ Intracranial calcification ☐ Cerebral / cortical atrophy

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☐ Abnormal cortical gyral patterns (lissencephaly, pachygyria, agyria, microgyria, polymicrogyria, schizencephaly)

☐ Corpus callosum abnormalities ☐ Cerebellar abnormalities ☐ Porencephaly

☐ Hydranencephaly ☐ Moderate or severe ventriculomegaly/hydrocephaly

☐ Fetal Brain Disruption Sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)

☐ Other major brain abnormalities

☐ Encephalocele ☐ Holoprosencephaly/ Arhinencephaly

☐ Other abnormalities

NAD.61. (*please describe below*)

NAD.62. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Not Performed

NAD.63. (Date:_____) *or* Age_____day(s)

NAD.64. Findings: *check all that apply* ☐ Normal

☐ Microcephaly ☐ Intracranial calcification ☐ Cerebral / cortical atrophy

☐ Abnormal cortical gyral patterns (lissencephaly, pachygyria, agyria, microgyria, polymicrogyria, schizencephaly)

☐ Corpus callosum abnormalities ☐ Cerebellar abnormalities ☐ Porencephaly

☐ Hydranencephaly ☐ Moderate or severe ventriculomegaly/hydrocephaly

☐ Fetal Brain Disruption Sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)

☐ Other major brain abnormalities

☐ Encephalocele ☐ Holoprosencephaly/ Arhinencephaly

☐ Other abnormalities

NAD.65. (*please describe below*)

NAD.66. Imaging study: ☐ Cranial ultrasound ☐ MRI ☐ CT ☐ Not Performed

NAD.67. (Date:_____) *or* Age_____day(s)

NAD.68. Findings: *check all that apply* ☐ Normal

☐ Microcephaly ☐ Intracranial calcification ☐ Cerebral / cortical atrophy

☐ Abnormal cortical gyral patterns (lissencephaly, pachygyria, agyria, microgyria, polymicrogyria, schizencephaly)

☐ Corpus callosum abnormalities ☐ Cerebellar abnormalities ☐ Porencephaly

☐ Hydranencephaly ☐ Moderate or severe ventriculomegaly/hydrocephaly

☐ Fetal Brain Disruption Sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)

☐ Other major brain abnormalities

☐ Encephalocele ☐ Holoprosencephaly/ Arhinencephaly

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

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☐ Other abnormalities
NAD.69. (*please describe below*)

NAD.70. Was a lumbar puncture performed: ☐ Yes ☐ No ☐ Unknown **NAD.71.** (Date:_____)
or Age_____day(s)

Postnatal Infection Testing (includes urine culture for CMV)		
NAD.72.	Toxoplasmosis infection:	☐ No ☐ Yes ☐ Unknown
NAD.73.	Cytomegalovirus infection:	☐ No ☐ Yes ☐ Unknown
NAD.74.	Herpes Simplex infection:	☐ No ☐ Yes ☐ Unknown
NAD.75.	Rubella infection:	☐ No ☐ Yes ☐ Unknown
NAD.76.	Lymphocytic choriomeningitis virus infection:	☐ No ☐ Yes ☐ Unknown
NAD.77.	Syphilis infection:	☐ No ☐ Yes ☐ Unknown

NAD.78. If yes for any postnatal infection testing, please describe results:

Postnatal (Infant) Cytogenetic Testing

NAD.79. Cytogenetic Test	**NAD.80. Date:**	**NAD.82. Specimen**	**NAD.83. Test Result**
☐ Karyotype ☐ FISH ☐ CGH microarray ☐ Other, specify _____	_____ **NAD.81. Infant Age:** _____ **months**	☐ Cord blood ☐ Peripheral blood ☐ Tissue ☐ Other, specify _____	☐ Normal ☐ Abnormal ☐ Unknown

NAD.84. Description of cytogenetic test findings (verbatim):

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

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NAD.85. Other tests/results/diagnosis (*include dates*):

Birth Defects Diagnosed or Suspected (Include Chromosomal Abnormalities and Syndromes)

Diagnostic Code	Certainty	Verbatim Description
	☐ Definite ☐ Possible/Probable	
	☐ Definite ☐ Possible/Probable	
	☐ Definite ☐ Possible/Probable	
	☐ Definite ☐ Possible/Probable	
	☐ Definite ☐ Possible/Probable	
	☐ Definite ☐ Possible/Probable	

Health Department Information

NAD.86. Name of person completing form: _____

NAD.87. Phone: _____

NAD.88. Email:_____**NAD.89. Date of form completion**_____

FOR INTERNAL CDC USE ONLY

Mother ID: **State/territory ID:**

PLEASE PROVIDE NAME / CONTACT INFORMATION FOR THE OUTPATIENT PEDIATRICIAN:

Name: _____ **Address:** _____ **Phone:** _____

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
AND PREVENTION
ATLANTA, GA 30329

Clinical Summary for Pediatric Healthcare Provider

Instructions for providers:

- Complete this form for infants EITHER 1) with clinical findings consistent with congenital Zika syndrome OR 2) who are born to a mother with laboratory evidence of possible Zika virus infection during the pregnancy
- Send this form to the outpatient pediatric healthcare provider who will receive the infant for follow-up care.

Infant's Name:	**Date of Birth:**
Mother's Name:	**Date of Birth:**

MATERNAL ZIKA VIRUS EXPOSURE *(Please check any reported exposures.)*

Mother has a history of Zika virus exposure during pregnancy through:

☐ travel to area with risk of Zika ☐ sexual exposure ☐ residence in an area at risk of Zika ☐ other exposure

Travel Dates and Location(s): _____

Comments: _____

MATERNAL ZIKA VIRUS TESTING *(Please record labs performed and results.)*

Mother was ☐ tested ☐ not tested

Date of Collection	Test Type* (e.g., Zika virus NAT, IgM, PRNT)	Result†

PRENATAL ZIKA-RELATED IMAGING *(Please record the overall assessment and describe any abnormalities.)*

Prenatal Imaging Findings: ☐ normal ☐ abnormal

Description of Abnormalities: _____

INFANT ZIKA VIRUS TESTING *(Please record labs performed and results.)*

Infant was ☐ tested ☐ not tested

Date of Collection	Test Type* (e.g., Zika virus NAT, IgM, PRNT)	Result†

INFANT EVALUATION RESULTS *(Please record evaluation results, describe any abnormalities.)*

- Birth Growth Parameters: Weight: _____ lb/kg Length: _____ in/cm HC: _____ in/cm
- Comprehensive Examination: ☐ normal ☐ abnormal

  Description of Abnormalities: _____
- Postnatal Head Imaging: ☐ normal ☐ abnormal

  Description of Abnormalities: _____
- Audiology Evaluation: ☐ normal ☐ abnormal

  Description of Abnormalities: _____
- Ophthalmology Examination: ☐ normal ☐ abnormal

  Description of Abnormalities: _____
- Other Evaluations:

  Description of Abnormalities: _____

CDC INFANT EVALUATION AND FOLLOW-UP CATEGORY *(Check one and refer to guidance¶ for next steps)*:

☐ Infant with clinical findings consistent with congenital Zika syndrome regardless of maternal testing results

☐ Infant without clinical findings consistent with congenital Zika syndrome who was born to a mother with laboratory evidence of possible Zika virus infection during the pregnancy

☐ Infant without clinical findings consistent with congenital Zika syndrome who was born to a mother without laboratory evidence of possible Zika virus infection

COMPLETED BY:

Printed Name:	Date:
Signature:	

OUTPATIENT PEDIATRIC HEALTHCARE PROVIDER

Name:

Address:

Phone:

Fax:

Email Address:

*Nucleic Acid Testing (NAT), Plaque Reduction Neutralization Test (PRNT)

†Guidance on lab test interpretation can be found at the following website: https://www.cdc.gov/zika/hc-providers/testresults.html. For questions or assistance please contact your local health department.

¶Further testing and evaluation of the infant might be needed according to published recommendations. Guidance can be found at the following site: https://www.cdc.gov/pregnancy/zika/testing-follow-up/evaluation-testing.html