



Updated August 9, 2017

NJDOH Zika Delivery Packet

New Jersey Department of Health (NJDOH) monitors all Zika-related guidance issued by the Centers for Disease Control and Prevention (CDC) and is responsible for determining how CDC recommendations can best be implemented in New Jersey. For Zika testing and assessment of mothers and infants, two departments within DOH are involved in these activities:

Communicable Disease Services Zika Team 609-826-5964

Family Health Services Zika Pregnancy Registry Team 609-292-5616

All pregnant women presenting for delivery should be screened for a history of Zika virus exposure (travel and sexual) during the current pregnancy and 8 weeks before conception. CDC's Zika screening tool for pregnant women can be found at the following website.

https://www.cdc.gov/zika/pdfs/zikapreg_screeningtool.pdf

For mothers exposed to Zika virus, the following documents and checklists are intended to streamline the process for evaluating and testing mothers and their infants at time of delivery and prior to discharge.

1. Zika Delivery Checklist for Birthing Hospitals
2. Maternal and Infant Zika Testing Recommendations at Delivery
3. Zika Delivery Testing Forms*
4. Zika Delivery Specimen Collection Guidance
5. Zika Neonate Assessment Form

*Fax completed forms to the number specified on each form.



NJDOH Zika Delivery Checklist for Birthing Hospitals

- **Review the attached NJDOH “Maternal and Infant Zika Testing Recommendations at Delivery” to determine which assessments to perform and if testing is indicated.**

- **Perform the following assessments on all infants.**
 - Comprehensive physical exam including head circumference
 - Standard newborn hearing screening

Depending on the level of possible Zika exposure, consider the following infant testing.

 - Infant head ultrasound
 - Ophthalmologic assessment

- **If Zika testing is indicated:**
 - **Collect placental/umbilical cord tissue. Send to your pathology lab promptly.**
 - Pathology lab should prepare FIXED specimens ONLY, labeled with mother's name.
 - Prepare several full thickness pieces, including sections of the placental disk, umbilical cord, membranes and any pathologic lesions.
 - Place into one or more containers with adequate formalin; store at room temperature.
http://www.state.nj.us/health/phel/documents/zika_supp_tech_bulletin_march2017.pdf

 - **Complete and return the maternal “NJDOH Zika Virus Patient Information Worksheet” and the “NJDOH Zika Delivery Testing Form (Infant).”**
 - Fax to NJDOH Communicable Disease Service at FAX: 609-826-4874 [Phone: 609-826-5964]. NJDOH will provide your laboratory with the authorization forms required to ship the specimens.

 - **Collect maternal serum and urine for Zika testing.**
 - Obtain sufficient blood to obtain a total of 3 ml of serum. Collect in a serum separator tube (tiger top, speckle top or gold top) and promptly send to your laboratory.
 - Obtain at least 3 ml of urine in a clean container; promptly send to laboratory
 - Process, store and ship as directed in the following NJDOH Zika technical bulletins:
http://www.state.nj.us/health/phel/documents/zika_tech_bulletin_update_071416.pdf
http://www.nj.gov/health/phel/documents/zika_supp_tech_bulletin_march2017.pdf

 - **Collect infant serum and urine for Zika testing.**
 - Obtain sufficient blood to obtain a total of 1.5 – 2 ml of serum. Collect in a serum separator tube (tiger top, speckle top or gold top) and promptly send to your laboratory.
 - Obtain at least 3 ml of urine in a clean container (catheterization not necessary); promptly send to laboratory.
 - Process, store and ship in same manner as for maternal specimens.

- **For the infants listed below, complete the attached NJ-specific “US Zika Pregnancy Registry Neonate Assessment Form.** Be sure to include name of post discharge pediatrician.
 - Infants born to mothers who have laboratory evidence of Zika during pregnancy
 - or
 - Infants with abnormalities suggestive of congenital Zika virus syndrome born to mothers with risk factors for Zika (regardless of maternal Zika test results)



Maternal and Infant Zika Testing Recommendations at Delivery

To request testing at NJDOH, complete the Zika Delivery Testing Forms and fax to 609-826-4874.
 Note: Placental/fetal tissue testing is only available through NJDOH.

<p>Apparently normal infants born to mothers who were not tested for Zika but have risk factors</p>	<p>OR</p>	<p>Apparently normal infants whose mother tested negative but:</p> <ul style="list-style-type: none"> - Mother’s specimen collected for Zika testing > 12 weeks after exposure - Mother had ongoing (daily or weekly) travel exposure
<ul style="list-style-type: none"> <input type="checkbox"/> Save and fix placental/cord tissue <u>if mother had symptoms of Zika during pregnancy</u> (fever, rash, conjunctivitis, arthralgia). <input type="checkbox"/> Perform the following: <ul style="list-style-type: none"> - Comprehensive physical exam including head circumference - Standard newborn hearing screen <input type="checkbox"/> Depending on level of possible Zika exposure, consider if additional evaluation is warranted, to include: <ul style="list-style-type: none"> - Infant head ultrasound - Ophthalmologic assessment <input type="checkbox"/> Based on these assessments, clinicians may consider: <ul style="list-style-type: none"> - Infant testing for Zika: serum (PCR and IgM) and urine (PCR). <input type="checkbox"/> Collect/order maternal Zika testing: serum (PCR and IGM) and urine (PCR) <u>if mother was symptomatic</u> (fever, rash, conjunctivitis, arthralgia) <u>AND is within 12 weeks of last Zika exposure</u>. [Not required if mother was already tested] 		

<p>Infants with abnormalities suggestive of congenital Zika virus syndrome</p>	<p>AND</p>	<p>OR</p>	<p>Infants (normal or with abnormalities) born to mothers who have laboratory evidence of Zika during pregnancy</p> <p>(includes Zika IgM+ / PRNT pending)</p>
<p>maternal risk factors for Zika (travel, sexual, etc) regardless of maternal test results</p>			
<ul style="list-style-type: none"> <input type="checkbox"/> Save and fix placental/cord tissue. <input type="checkbox"/> Collect/order infant Zika testing: serum (PCR and IgM) & urine (PCR) within 2 days of birth <input type="checkbox"/> Perform the following: <ul style="list-style-type: none"> - Comprehensive physical exam including head circumference - Neurologic assessment - Infant head ultrasound - Standard newborn hearing screen - Ophthalmologic assessment <input type="checkbox"/> Complete Zika Neonate Assessment Form. <input type="checkbox"/> Collect/order maternal Zika testing: serum (PCR & IgM) & urine (PCR) <u>if mother was symptomatic</u> (fever, rash, conjunctivitis, arthralgia) <u>AND is within 12 weeks of last Zika exposure</u>. [Not required if mother was already tested] 			

Source: https://www.cdc.gov/mmwr/volumes/66/wr/mm6629e1.htm?s_cid=mm6629e1_w;
<https://www.cdc.gov/zika/hc-providers/infants-children/evaluation-testing.html>

NJDOH ZIKA VIRUS PATIENT INFORMATION WORKSHEET (MATERNAL)

CDRSS #: _____

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 **fax to the NJDOH Zika Team at 609-826-4874**.

NJDOH guidance on current criteria for testing at: www.state.nj.us/health/cd/topics/zika.shtml.

CDC's Zika Travel Information page – identifies areas experiencing Zika transmission: www.cdc.gov/zika/geo

Patient Name (Last name, First name)		Date of Birth ____/____/____	Patient Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Patient Address	City	State	Zip Code Telephone Number () -
Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander/Native Hawaiian	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Other _____		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic

Maternal Zika Exposure History (select all that apply)

Date of delivery ____ / ____ / ____	Are there infant abnormalities suggestive of Zika at delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Maternal Symptom Currently symptomatic Recovered /Formerly symptomatic Asymptomatic*

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

<input type="checkbox"/> Travel to area with Zika <input type="checkbox"/> Ongoing travel (at least weekly) to area with Zika	Travel location(s):	Travel dates: From: ____/____/____ To: ____/____/____
		From: ____/____/____ To: ____/____/____

<input type="checkbox"/> Unprotected sexual contact with Zika exposed partner	Date(s) of first and last unprotected sexual contact with Zika exposed partner: ____/____/____	First: ____/____/____ Last: ____/____/____
	Sexual partner's travel location(s), if applicable: _____	Sexual partner's travel dates: From: ____/____/____ To: ____/____/____

<input type="checkbox"/> Congenital/Perinatal <input type="checkbox"/> Laboratory/Healthcare <input type="checkbox"/> Other Exposure (specify) _____	Exposure dates: From: ____/____/____ To: ____/____/____
<input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Organ Recipient _____	

List all signs and symptoms with onset/resolution dates:		Other Symptoms (e.g., Headache, Myalgia, Eye pain, etc.): Comments (if applicable)									
<input type="checkbox"/> Fever <input type="checkbox"/> Rash <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Arthralgia (joint pain) <input type="checkbox"/> Neurological symptoms (specify) _____	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Onset Date (mm/dd/yy)</td> <td style="text-align: center;">Resolution Date (mm/dd/yy)</td> </tr> <tr> <td style="text-align: center;">____ / ____ / ____</td> <td style="text-align: center;">____ / ____ / ____</td> </tr> <tr> <td style="text-align: center;">____ / ____ / ____</td> <td style="text-align: center;">____ / ____ / ____</td> </tr> <tr> <td style="text-align: center;">____ / ____ / ____</td> <td style="text-align: center;">____ / ____ / ____</td> </tr> <tr> <td style="text-align: center;">____ / ____ / ____</td> <td style="text-align: center;">____ / ____ / ____</td> </tr> </table>		Onset Date (mm/dd/yy)	Resolution Date (mm/dd/yy)	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
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____ / ____ / ____	____ / ____ / ____										

Immunization history and year of immunization if known:

Yellow Fever Vaccine _____ Japanese Encephalitis Vaccine _____ Tickborne Encephalitis Vaccine _____

Previous history (year) of flavivirus/arboviral disease

West Nile Virus _____ Chikungunya Virus _____ Previous Zika diagnosis (mm/yy) _____

Dengue Virus _____ Powassan Virus _____ Other flavivirus/arboviral disease _____

Submitter Information (Physician who is ordering Zika test)

Name of Health Care Provider		Patient ID Number
Institution Name	Address	
Phone () -	Fax (to receive test results) () -	E-mail Address:
Point of Contact if not Provider		Lab Name (where the patient will go to have their blood drawn)

NJDOH ZIKA DELIVERY TESTING FORM (INFANT)

1. Complete this form and fax it to the NJ Department of Health (DOH): 609- 826-4874.
2. Collect specimens as indicated in the attached "Maternal and Infant Zika Testing Recommendations at Delivery."
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 <input type="checkbox"/> Male <input type="checkbox"/> Female
Infant Home Address	City	State
	Zip Code	Home Telephone Number
Race <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other/Unknown <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander		Hispanic Origin <input type="checkbox"/> Yes <input type="checkbox"/> Other/Unknown <input type="checkbox"/> No

Maternal Information

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

Gestational age: ____ weeks ____ days	Delivery type: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section	Delivery complications: <input type="checkbox"/> Yes <input type="checkbox"/> No
Birth head circumference _____ cm	Microcephaly <input type="checkbox"/> No <input type="checkbox"/> Yes	
Birth weight _____ grams	Other abnormalities <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, describe)	
Birth length _____ cm		_____

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 Sendout:	Phone:	Fax:	E-mail:
Laboratory Contact for Pathology (placental tissue):	Phone:	Fax:	E-mail:

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
<p>Collect enough blood to yield:</p> <p><u>Infant:</u> 1.5-2.0 ml of serum</p> <p><u>Mother:</u> 3.0 ml of serum</p>	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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. 	<p>For information on packaging and shipping refer to the Zika Technical Bulletins at: http://nj.gov/health/phel/index.shtml</p>

Urine from Infants and Mothers

Minimum Volume	Container	Storage	Additional Instructions
<p>Collect urine on same day as serum:</p> <ul style="list-style-type: none"> 3.0 ml of urine 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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. 	<p>For information on packaging and shipping refer to the Zika Technical Bulletins at: http://nj.gov/health/phel/index.shtml.</p>

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
<p><u>Placenta and fetal membranes:</u></p> <ul style="list-style-type: none"> 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. <p><u>Umbilical cord:</u></p> <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Tissue testing must be pre-approved by CDS 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.



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

Return completed form to the secure fax at the NJDOH Zika Pregnancy Registry:

Fax: 609-292-8235 (Phone: 609-292-5616)

Infant Name: _____, _____ Delivery Facility: _____
(last name) (first name)

NAD.1. Infant's State/Territory ID _____	NAD.2. Mother's State/Territory ID _____	NAD.3. DOB: _____ <input type="checkbox"/> Live birth <input type="checkbox"/> Stillbirth ≥ 20 weeks	NAD.4. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous/undetermined
NAD.5. Gestational age at delivery: _____ weeks _____ days	NAD.6. Based on: (check all that apply) <input type="checkbox"/> LMP Date: _____ <input type="checkbox"/> 1 st trimester ultrasound <input type="checkbox"/> 2 nd trimester ultrasound <input type="checkbox"/> 3 rd trimester ultrasound <input type="checkbox"/> Other _____		NAD.7. Maternal age at delivery _____ years
NAD.8. State/Territory reporting: _____		NAD.9. County reporting: _____	
NAD.10. Delivery type: <input type="checkbox"/> Vaginal <input type="checkbox"/> Caesarean section		NAD.13. Arterial cord blood pH (if performed): _____	
NAD.11. Delivery complication: <input type="checkbox"/> No <input type="checkbox"/> Yes		NAD.14. Venous cord blood pH (if performed): _____	
NAD.12. If yes, please describe: _____			
NAD.15. Placental exam (based on path report): <input type="checkbox"/> No <input type="checkbox"/> Yes			
NAD.16. If yes, <input type="checkbox"/> Normal <input type="checkbox"/> Abruption <input type="checkbox"/> Inflammation <input type="checkbox"/> 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: _____ <input type="checkbox"/> cm _____ <input type="checkbox"/> in		NAD.23. Birth weight: _____ <input type="checkbox"/> grams _____ <input type="checkbox"/> lbs/oz	NAD.25. Birth length: _____ <input type="checkbox"/> cm _____ <input type="checkbox"/> in
NAD.20. <input type="checkbox"/> Molding present		NAD.24. Birth weight percentile: _____	NAD.26. Birth length percentile: _____
NAD.21. Physican report: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
NAD.22. HC percentile: _____			
NAD.27. Repeat head circumference: _____ <input type="checkbox"/> cm _____ <input type="checkbox"/> in		NAD.31. Admitted to Neonatal Intensive Care Unit: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, reason:</i> _____	
NAD.28. Date performed: _____ <i>or</i> Age _____ day(s)		NAD.32. Neonatal death: <input type="checkbox"/> No <input type="checkbox"/> Yes	
NAD.29. Physican report: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		NAD.33. Date: _____ <i>or</i> Age at death _____ days	
NAD.30. HC percentile: _____		NAD.34. Cause of death: _____	
NAD.35. Microcephaly (head circumference <3%ile):		NAD.36. Seizures:	

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

No Yes

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)

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 Arthrogyposis (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)

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

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

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

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

- 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.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:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
NAD.73.	Cytomegalovirus infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
NAD.74.	Herpes Simplex infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
NAD.75.	Rubella infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
NAD.76.	Lymphocytic choriomeningitis virus infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
NAD.77.	Syphilis infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown

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

Postnatal (Infant) Cytogenetic Testing

NAD.79. Cytogenetic Test <input type="checkbox"/> Karyotype <input type="checkbox"/> FISH <input type="checkbox"/> CGH microarray <input type="checkbox"/> Other, specify _____	NAD.80. Date: _____ NAD.81. Infant Age: _____ months	NAD.82. Specimen <input type="checkbox"/> Cord blood <input type="checkbox"/> Peripheral blood <input type="checkbox"/> Tissue <input type="checkbox"/> Other, specify _____	NAD.83. Test Result <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown
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NAD.84. Description of cytogenetic test findings (verbatim):

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

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

Birth Defects Diagnosed or Suspected (Include Chromosomal Abnormalities and Syndromes)		
Diagnostic Code	Certainty	Verbatim Description
	<input type="checkbox"/> Definite <input type="checkbox"/> Possible/Probable	
	<input type="checkbox"/> Definite <input type="checkbox"/> Possible/Probable	
	<input type="checkbox"/> Definite <input type="checkbox"/> Possible/Probable	
	<input type="checkbox"/> Definite <input type="checkbox"/> Possible/Probable	
	<input type="checkbox"/> Definite <input type="checkbox"/> Possible/Probable	
	<input type="checkbox"/> Definite <input type="checkbox"/> 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: _____
<small>Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-1101)</small>		

Infant serum and urine should be obtained for Zika testing within 2 days of delivery. NJDOH CDS will notify Pediatrician of infant Zika results.

Please provide the name and contact information for the pediatrician who will be following the infant after discharge from the hospital.

Pediatrician Name: _____

Practice/Address: _____

Phone Number: _____

Fax Number: _____