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

For mothers exposed to Zika virus who present to a NJ birthing hospital, 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. Recommendations for Maternal and Infant Zika Testing
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

- ☐ **Designate a staff member to notify NJDOH Zika Pregnancy Registry Team when a Zika- exposed woman presents for delivery**.
  - During business hours, call 609-292-5616. If the delivery occurs on evening or night shift, collect specimens as directed below and notify NJDOH on next business day.

- ☐ **Review the attached NJDOH "Recommendations for Maternal and Infant Zika Testing" to determine which specimens to collect and assessments to perform.**

- ☐ **After delivery, complete and return the maternal and infant "Zika Delivery Testing Forms."**
  - 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 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

- ☐ **If indicated, 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.state.nj.us/health/phel/documents/zika_supp_tech_bulletin_march2017.pdf

- ☐ **Draw infant serum for Zika testing**.
  - Obtain sufficient blood to produce 1.5 ml – 2 ml of serum. Collect in a serum separator tube (tiger top, speckle top or gold top) and promptly send to your laboratory. Process, store and ship as directed for maternal serum and urine.

- ☐ **Obtain infant urine for Zika testing**.
  - Collect 2-3 ml, without preservative, in a clean container. (Catheterization not necessary) Promptly send to your laboratory to process, store and ship as for maternal serum and urine.

- ☐ **Perform a comprehensive physical examination of the infant.**
  - Include a precise measurement of head circumference, length and weight, assessment of gestational age, examination for neurologic abnormalities and dysmorphic features. https://www.cdc.gov/zika/pdfs/pediatric-evaluation-follow-up-tool.pdf

- ☐ **Perform a standard newborn hearing screening.**

- ☐ **Perform a head ultrasound on the infant.**

- ☐ **Obtain a second head circumference measurement at 24 to 48 hours.**

- ☐ **Identify the pediatrician who will be caring for the infant after discharge.**
  - Notify pediatrician that **i**f infant tests Zika PCR+ or IgM+, a comprehensive ophthalmologic exam and hearing ABR testing are recommended before 1 month of age. If outpatient pediatrician is listed on form below, they will be notified of infant's Zika test results.

- ☐ **Before infant discharge, complete the NJ-specific "U.S. Zika Pregnancy Registry and Birth Defects Surveillance – Integrated Neonate Assessment Form."**
  - Fax to NJDOH: 609-292-8235 **[**Phone: 609-292-5616]

Recommendations for Maternal and Infant Zika Testing at Time of Delivery by a Mother Exposed to Zika Virus

To request testing, complete the enclosed Zika Delivery Testing Forms. Fax to NJDOH Communicable Disease Service: 609-826-4874 or send through encrypted e-mail to: CDS.ZikaTEam@doh.nj.gov. NJDOH will provide the required approval forms to the delivery hospital laboratory.

Apparently normal infants

Mother tested positive for Zika infection	Mother not yet tested for Zika	Mother tested negative for Zika infection	
		All or part of Zika exposures occurred more than 12 weeks prior to testing	All Zika exposures occurred in the 12 weeks prior to testing
Save and fix placental/cord tissue Collect infant serum & urine within 2 days of birth Perform infant head ultrasound before discharge Complete Zika Neonate Assessment Form	Save and fix placental/cord tissue Collect infant serum & urine within 2 days of birth Perform infant head ultrasound before discharge Complete Zika Neonate Assessment Form If the mother's last Zika exposure was ≤ 12 weeks collect maternal serum and urine for Zika testing	Save and fix placental/cord tissue Collect infant serum & urine within 2 days of birth Perform infant head ultrasound before discharge Complete Zika Neonate Assessment Form	No Zika testing or assessments are indicated

Infants born with abnormalities consistent with congenital Zika syndrome**

Save and fix placental/cord tissue

Collect infant serum & urine within 2 days of birth

Before discharge, perform the following diagnostic studies:
- Infant head ultrasound
- Hearing ABR
- Comprehensive opthalmologic exam
- CBC, LFTs, metabolic panel

Complete Zika Neonate Assessment Form

*Source of NJDOH recommendations - CDC: https://www.cdc.gov/zika/pdfs/placental-testing-guidance.pdf

** CDC website: https://www.cdc.gov/zika/hc-providers/infants-children/zika-syndrome-birth-defects.html

May 2017

NJDOH ZIKA DELIVERY TESTING FORM (MATERNAL)

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 "Recommendations for Maternal and Infant Zika Testing."

3. NJDOH will provide the birthing hospital laboratory with the required authorization form for shipping to NJDOH.

Patient Information

Patient Name (Last name, First name)				Date of Birth ___/___/_____
Patient Address	City	State	Zip Code	Telephone Number

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

Hispanic Origin
☐ Yes ☐ Other/Unknown
☐ No

Zika Exposure History (select all that apply)

☐ Travel to area with Zika	Travel location(s):	Travel dates: From: ___/___/____ To: ___/___/___
☐ Unprotected sexual contact with Zika exposed partner	Date 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: ___/___/____

☐ Congenital/Perinatal ☐ Laboratory/Healthcare ☐ Other Exposure (*specify*) _____
☐ Blood Transfusion ☐ Organ Recipient

Exposure dates: From: To:

Symptom Status ☐ Currently symptomatic ☐ Recovered /Formerly symptomatic ☐ Asymptomatic

Select all signs and symptoms with onset/resolution dates:

	Onset Date *(dd/mm/yy)*	Resolution Date *(dd/mm/yy)*
☐ Fever	_____ /_____/_____	_____ /_____/_____
☐ Rash	_____ /_____/_____	_____ /_____/_____
☐ Conjunctivitis	_____ /_____/_____	_____ /_____/_____
☐ Arthralgia (joint pain)	_____ /_____/_____	_____ /_____/_____
☐ Neurological symptoms (*specify)*	_____ /_____/_____	_____ /_____/_____

Other Symptoms (e.g., Headache, Myalgia, Eye pain, etc.):

Comments (*if applicable)*

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 _____ ☐ Other flavivirus/arboviral disease_____
☐ Dengue Virus _____ ☐ Powassan Virus _____

Submitter Information (Person ordering Zika test)

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

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 "Recommendations for Maternal and Infant Zika Testing."

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	Hispanic Origin
☐ White ☐ American Indian/Alaskan Native ☐ Other/Unknown ☐ Black ☐ Asian/Pacific Islander	☐ Yes ☐ Other/Unknown ☐ No

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 abnormalities ☐ No ☐ Yes (If 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 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
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 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.

May 2017

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:** _____ ☐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.** Physican 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.** Physican 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):		**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 ☐ 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 emisions (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

☐ 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:	☐ 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.81. Infant Age:**	**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):

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**
	☐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:**

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: _____