



# 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 via SAMS or secure FTP—request access from [ZIKApregnancy@cdc.gov](mailto:ZIKApregnancy@cdc.gov)  
 The form can also be sent by encrypted email to this address or by secure fax to **404-718-1013** or **404-718-2200**  
 Contact Pregnancy & Birth Defects Task Force phone number: **770-488-7100**

<b>NAD.1. Infant's State/Territory ID</b> _____	<b>NAD.2. Mother's State/Territory ID</b> _____	<b>NAD.3. DOB:</b> ____/____/____ <input type="checkbox"/> Live birth <input type="checkbox"/> Stillbirth ≥20 weeks	<b>NAD.4. Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous/undetermined
<b>NAD.5. Gestational age at delivery:</b> _____ weeks _____ days	<b>NAD.6. Based on: (check all that apply)</b> <input type="checkbox"/> LMP ____/____/____ <input type="checkbox"/> 1 <sup>st</sup> trimester ultrasound <input type="checkbox"/> 2 <sup>nd</sup> trimester ultrasound <input type="checkbox"/> 3 <sup>rd</sup> trimester ultrasound <input type="checkbox"/> Other _____	<b>NAD.7. Maternal age at delivery</b> _____ years	
<b>NAD.8. State/Territory reporting:</b> _____		<b>NAD.9. County reporting:</b> _____	
<b>NAD.10. Delivery type:</b> <input type="checkbox"/> Vaginal <input type="checkbox"/> Caesarean section <b>NAD.11. Delivery complication:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>NAD.12. If yes, please describe:</b> _____		<b>NAD.13. Arterial cord blood pH (if performed):</b> _____ <b>NAD.14. Venous cord blood pH (if performed):</b> _____	
<b>NAD.15. Placental exam (based on path report):</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>NAD.16. If yes,</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abrupton <input type="checkbox"/> Inflammation <input type="checkbox"/> Other abnormality (please describe)			
<b>NAD.17. Apgar score:</b> 1 min _____ / 5 min _____		<b>NAD.18. Infant temp (if abnormal):</b> _____ °F or _____ °C	
<b>Physical Examination (record earliest measurements taken)</b>			
<b>NAD.19. Birth head circumference:</b> _____ <input type="checkbox"/> cm    _____ <input type="checkbox"/> in <b>NAD.20.</b> <input type="checkbox"/> Molding present <b>NAD.21. Physican report:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <b>NAD.22. HC percentile:</b> _____		<b>NAD.23. Birth weight:</b> _____ <input type="checkbox"/> grams _____ <input type="checkbox"/> lbs/oz <b>NAD.24. Birth weight percentile:</b> _____	<b>NAD.25. Birth length:</b> _____ <input type="checkbox"/> cm _____ <input type="checkbox"/> in <b>NAD.26. Birth length percentile:</b> _____
<b>NAD.27. Repeat head circumference:</b> _____ <input type="checkbox"/> cm    _____ <input type="checkbox"/> in <b>NAD.28. Date performed</b> ____/____/____ or Age _____ day(s) <b>NAD.29. Physican report:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <b>NAD.30. HC percentile:</b> _____		<b>NAD.31. Admitted to Neonatal Intensive Care Unit:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, reason:</i> _____ <b>NAD.32. Neonatal death:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>NAD.33. Date</b> ____/____/____ or Age at death _____ days <b>NAD.34. Cause of death:</b> _____	
<b>NAD.35. Microcephaly (head circumference &lt;3%ile):</b> <input type="checkbox"/> No <input type="checkbox"/> Yes		<b>NAD.36. Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>NAD.37. Neurologic exam: (check all that apply)</b> <input type="checkbox"/> Not performed <input type="checkbox"/> Unknown <input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia/Spasticity <input type="checkbox"/> Hyperreflexia <input type="checkbox"/> Irritability <input type="checkbox"/> Tremors <input type="checkbox"/> Other neurologic abnormalities <b>NAD.38. (please describe below)</b>			
<b>NAD.39. Splenomegaly by physical</b>	<b>NAD.41. Hepatomegaly by physical</b>	<b>NAD.43. Skin rash by</b>	



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<p><b>exam:</b>  <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown  <b>NAD.40.</b> (please describe)</p>	<p><b>exam:</b>  <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown  <b>NAD.42.</b> (please describe)</p>	<p><b>physical exam:</b>  <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown  <b>NAD.44.</b> (please describe)</p>
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**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  
 Abnormal cortical gyral patterns (lissencephaly, pachygyria, agyria, microgyria, polymicrogyria,





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**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)**

<b>NAD.72.</b>	Toxoplasmosis infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>NAD.73.</b>	Cytomegalovirus infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>NAD.74.</b>	Herpes Simplex infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>NAD.75.</b>	Rubella infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>NAD.76.</b>	Lymphocytic choriomeningitis virus infection:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
<b>NAD.77.</b>	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**

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



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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
	<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:** \_\_\_\_\_

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)