



U.S. Zika Pregnancy Registry and Birth Defects Surveillance — Integrated Supplemental Maternal Prenatal Imaging and Diagnostics 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 secure fax (410-225-7615) or encrypted email (dhmh.zikapregnancy@maryland.gov).

Please direct questions to the email listed above or call 410-767-6700 and ask to speak to the ZPR Coordinator

SIF.1. State/Territory ID: _____		SIF.2. State/Territory reporting: _____		
		SIF.3. County reporting: _____		
SIF.4. Date(s) of ultrasound(s): _____ <input type="checkbox"/> SIF.5. Check if date approximated SIF.6. If date not known, Gestational age _____ weeks) (days)	SIF.7. Overall fetal ultrasound results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
	SIF.8. <input type="checkbox"/> Reported by patient/healthcare provider <input type="checkbox"/> Ultrasound report			
	SIF.9. Head circumference (HC) _____ cm			
	SIF.10. <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (<i>by physician report</i>)			
	SIF.11. Biparietal diameter (BPD) _____ cm			
	SIF.12. Femur length (FL) _____ cm			
	SIF.13. Abdominal circumference (AC) _____ cm			
	SIF.14. <input type="checkbox"/> Symmetric intrauterine growth restriction (IUGR) <input type="checkbox"/> Asymmetric IUGR (HC>AC or HC>FL)			
	SIF.15. Microcephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.16. Intracranial calcifications	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.17. Cerebral / cortical atrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.18. Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.19. Corpus callosum abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.20. Cerebellar abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.21. Porencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.22. Hydranencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.23. Moderate or severe ventriculomegaly/hydrocephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.24. Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.25. Other major brain abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.26. Anencephaly / acrania	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.27. Encephalocele	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.28. Spina bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
SIF.29. Holoprosencephaly/arhinencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.30. Structural eye abnormalities/dysplasia	<input type="checkbox"/> No <input type="checkbox"/> Yes	
SIF.31. Arthrogryposis	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.32. Clubfoot	<input type="checkbox"/> No <input type="checkbox"/> Yes	
SIF.33. Hydrops	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.34. Ascites	<input type="checkbox"/> No <input type="checkbox"/> Yes	
SIF.35. Other	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:			
SIF.36. Description of abnormal ultrasound findings:				



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SIF.37. Date(s) of Ultrasound(s): <input type="checkbox"/> SIF.38. check if date approximated SIF.39. if date not known, gestational age _____ (weeks) (days)	SIF.40. Overall fetal ultrasound results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
	SIF.41. <input type="checkbox"/> Reported by patient/healthcare provider SIF.42. <input type="checkbox"/> Ultrasound report			
	SIF.43. Head Circumference (HC) _____ cm SIF.44. <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal (<i>by physician report</i>)			
	SIF.45. Biparietal diameter (BPD) _____ cm SIF.46. Femur length (FL) _____ cm SIF.47. Abdominal circumference (AC) _____ cm			
	SIF.48. <input type="checkbox"/> Symmetric IUGR <input type="checkbox"/> Asymmetric IUGR (HC>AC or HC>FL)			
	SIF.49. Microcephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.50. Intracranial calcifications	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.51. Cerebral / cortical atrophy	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.52. Abnormal cortical gyral patterns (e.g., polymicrogyria, lissencephaly, pachygyria, schizencephaly, gray matter heterotopia)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.53. Corpus callosum abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.54. Cerebellar abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.55. Porencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.56. Hydranencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.57. Moderate or severe ventriculomegaly/hydrocephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.58. Fetal brain disruption sequence (collapsed skull, overlapping sutures, prominent occipital bone, scalp rugae)	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.59. Other major brain abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.60. Anencephaly / acrania	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.61. Encephalocele	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.62. Spina bifida	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.63. Holoprosencephaly/arhinencephaly	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.64. Structural eye abnormalities/dysplasia	<input type="checkbox"/> No <input type="checkbox"/> Yes
	SIF.65. Arthrogyposis	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.66. Clubfoot	<input type="checkbox"/> No <input type="checkbox"/> Yes
SIF.67. Hydrops	<input type="checkbox"/> No <input type="checkbox"/> Yes	SIF.68. Ascites	<input type="checkbox"/> No <input type="checkbox"/> Yes	
SIF.69. Other	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:			

SIF.70. Description of abnormal ultrasound findings:

Health Department Information

SIF.71. Name of person completing form: _____

SIF.72. Phone: _____ **SIF.73. Email:** _____

SIF.74. Date form completed _____

FOR INTERNAL CDC USE ONLY

Mother ID: _____ **State/Territory ID:** _____ **Zika T ID:** _____

R number: _____ **Mother infection type:** Confirmed Probable Possible Exclude

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).