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