Attachment 1

FOLLOW-UP NEWBORN, INFANT AND CHILD MICROCEPHALY PROTOCOL / ZIKA EXPOSURE

Date of follow-up: _____/_____/_____ Birth date _____/_____/_____

Mother´s name: _____

Child name: _____

Address: _____

Telephone: _____ Best time for contact: ( ) Morning ( ) Afternoon ( ) Evening

INFANT / NEWBORN DATA:

Delivery : ( )0. vaginal ( ) 1.Cesaran section ( ) 2.forceps ( ) 999.non-referred / unknown

- Gestational Age

Based on:	☐ LMP (last menstrual period) ☐Ultrasound ☐ Assisted reprodutive technology ☐Other (specify)

Birth data	☐ Singleton ☐ Twin (1st) ☐ Twin (2nd) ☐other: _____

- Birth weight_____ Birth length_____ Birth head circumference_____
- Apgar score 5 min_____
- Labor complications: ( )0.no ( ) 1.yes ( )999. non-referred / unknown
- If yes, describe:_____
- Perinatal events: ( ) No ( ) Yes If yes, describe:

_____

PHYSICAL EXAMINATION (UP TO 24 H):

Maximum temperature		____.__°C ☐Oral ☐☐ Ear ☐☐ Anal ☐☐Axillary ☐Another (specify):	
Respiratory rate			ipm
Heart Rate			bpm
Capillary filling time			seconds
Peripheral oxygen saturation			%
Cardiovascular system	☐Normal ☐Abnormal ☐Unknown	If abnormal, describe	
Sistema respiratório	☐Normal ☐Abnormal ☐ Unknown	If abnormal, describe	
Gastrointestinal system	☐Normal ☐Abnormal ☐ Unknown	☐ jaundice ☐ abdominal pain ☐Hepatomegaly ☐ Splenomegaly ☐ Other (specify) :	
Crying type	☐ normal ☐ weak ☐ absent ☐ Other (specify) :		
Asymmetrical tonic neck reflex	☐Present ☐**a**bsent ☐ not done	**Moro Reflex**	☐Present ☐Absent ☐Not done
Search Reflex	☐Present ☐Absent ☐Not done	**Sucking reflex**	☐Present ☐Absent ☐Not done
Grasp reflex	☐Present ☐Absent ☐Not done		
Seizures	☐Generalized ☐Focal ☐absent ☐**unknown**		If yes, describe:
Paralysis	☐General ☐Ascendent ☐absent ☐ unknown		If yes, describe:
Hypotonia	☐Yes ☐No ☐Unknown		
Hypertonia or Spasticity	☐Yes ☐No ☐Unknown		If yes, describe:
Contractures	☐Yes ☐No ☐Unknown		If yes, describe:
Other neurologic signs	☐Yes ☐No		If yes, describe:
Other movements	☐Yes ☐No		If yes, describe:
Rash	☐Yes ☐ No ☐Unknown If yes, describe:		If yes, onset date of skin rash (DD/MM/YYYY) **__ __ /__ __ / 20 __**
Edema	☐Yes ☐No ☐Unknown		If yes, describe:

BIRTH ABNORMALITIES (UP TO 24 H)

Fontanelles	Anterior: ☐Yes ☐No ☐ unknown	Posterior: ☐Yes ☐No ☐unknown	Bulging: ☐Yes ☐No ☐unknown
Cephalohematoma	☐ Yes ☐No ☐unknown	Subgaleal Hemorrhage	☐Yes ☐No ☐Unknown
Craniosinostosis	☐Yes ☐No ☐unknown If yes, describe:	Omphalocele	☐Yes ☐No ☐Unknown
Skull skin excess	☐Present ☐Absent If yes, describe:	Prominent occiput	☐ Present ☐ Absent
Down Syndrome characteristics	☐Yes ☐No ☐ unknown	Neural tube defects	☐yes ☐No ☐ unknown
Facial dismorphism	☐yes ☐No ☐ unknown If yes, describe:	Cleft palate / lip	☐ Yes ☐No ☐unknown
Eye abnormalities	☐ Yes ☐No ☐unknown If yes, describe:	Ear abnormalities	☐ Anotia/microtia ☐ Other (describe): _____ ☐ No ☐ Unknown
Hemangiomas	☐ Present ☐ Absent	☐ Facial ☐ Other location	Number : _____ Location:_____
Congenital cardiopathies	☐ Yes ☐No ☐ unknown	If yes, describe	
Gastroschisis	☐Sim ☐Não ☐Desconhecido	Hernia umbilical	☐Yes ☐No ☐Unknown
Hand abmormalities	☐ Polydactyly ☐ Absence of one or more fingers ☐ Absent ☐ Unknown ☐ Other (specify):	Foot abnormalities	☐ abnormal width between toes ☐ clubfoot _____ ☐ No ☐ Unknown ☐ Other (specificy):
Artrogriposis	☐Yes ☐No ☐Unknown	If yes, describe:	
Superior / inferior limbs abnormalities	☐Yes ☐No ☐ Unknown	If yes, describe: Describe which member	
Any Other abnormality / importante findings	☐Yes ☐No ☐Desconhecido	If yes, describe	

FAMILY HISTORY

- Genetic syndromes ( ) no ( ) yes Describe: _____
- Microcephaly ( ) no ( ) yes
- Neurologic diseases ( ) no ( ) yes Describe_____
- Other_____

LABORATORY EXAMS

Date (dd/mm/ano):	__ / __ / 20 __			
Test	result	Unity		
Reactive C protein		mg/L		other:_____
Erythrocyte sedimentation rate		mm		other:_____
Procalcitonine		ng/mL		other:_____
Hemoglobine		g/L	g/dL	other:_____
Hematocrite		%		other:_____
Lekocytes		$x10^9$/L	$x10^3$/µL	other:_____
Neutrophils		$10^3/mm^3$	%	other:_____
Lymphocytes		$10^3/mm^3$	%	other:_____
Monocytes		$10^3/mm^3$	%	other:_____
Eosinophils		$10^3/mm^3$	%	other:_____
Basophils		$10^3/mm^3$	%	other:_____
MCV		μm^3		other:_____
Erithrocytes		$x10^9$/L *or*	$x10^3$/µL	other:_____
Platelets		$x10^9$/L *or*	$x10^3$/µL	other:_____
aPTT		Seconds		
PT		Seconds		
BUN		mmol/L	mg/dL	other:_____
Albumin		g/L		other:_____
Sodium		mEq/L		other:_____
Potassium		mEq/L		other:_____
Calcium		mmol/L		other:_____
Phosphorus		mg/dL		other:_____
Magnesium		mmol/L		other:_____
Total protein		g/dL		other:_____
Creatinine		µmol/L	mg/dL	other:_____
Glucose, serum		mmol/L	mg/dL	other:_____
Amylase		U/L		other:_____
Bilirubin		µmol/L	mg/dL	other:_____
AST		U/L		other:_____
ALT		U/L		other:_____
Alkalyne phosphatasis		U/L		other:_____
GGT		U/L		other:_____
CK		U/L		other:_____
Other (specificy):		Unit:_____		
Other (specify):		Unit:_____		
Blood smear	Yes Not done	Unknown		
If yes, describe				

EAR / EYE TESTS

Test	Results	If abnormal, describe:
Fundoscopy	☐Normal ☐Abnormal ☐Not done	
Red reflex test	☐Present ☐Absent ☐Not done	
Cataract	☐Normal ☐Abnormal ☐ Not done	
Chorioretinitis	☐Present ☐Absent ☐ Not done	
Hearing test (specify the test performed)	☐Normal ☐Abnormal ☐ Not done	

IMAGES

(IF ABNORMAL, DESCRIBE)

Neuroimage	ResultS				Attached image	Attached report
		Type of the image	**Location**	**size**		
Brain ultrasound	☐Normal ☐Abnormal ☐not done				☐ **yes** ☐ **no**	☐**yes** ☐No
Brain CT scan	☐Normal ☐Abnormal ☐not done				☐**yes** ☐No	☐ **yes** ☐No
MRI	☐Normal ☐Abnormal ☐not done				☐ **Yes** ☐No	☐ **Yes** ☐No
Other (specify):	☐Normal ☐Abnormal ☐not done				☐ **yes** ☐No	☐**yes** ☐No

SEROLOGY AND PCR

Test	**Was this test done?**	**Date** *(dd/mm/YYYY)*	**Results**
RT-PCR ZIKA:			
- blood	yes No	I__I__I/I__I__I/I__I__I__I__I	Positive Negative
- Urine	yes No	I__I__I/I__I__I/I__I__I__I__I	Positive Negative
- Placenta	yes No	I__I__I/I__I__I/I__I__I__I__I	Positive Negative
ZIKA Serology	Yes No	I__I__I/I__I__I/I__I__I__I__I	IgM Pos Neg unknown IgG Pos Neg unknown
Dengue serology	Yes No	I__I__I/I__I__I/I__I__I__I__I	IgM Pos Neg unknown
			IgG Pos Neg unknown
Toxoplasmosis	Yes No	I__I__I/I__I__I/I__I__I__I__I	Positive Negative
Rubella	Yes No	I__I__I/I__I__I/I__I__I__I__I	Positive Negative
Cytomegalovirus	Yes No	I__I__I/I__I__I/I__I__I__I__I	Positive Negative
Syphilis	Yes No	I__I__I/I__I__I/I__I__I__I__I	Positive Negative
Herpes Simplex	Yes No	I__I__I/I__I__I/I__I__I__I__I	Positive Negative
Other (specificy)	Yes No	I__I__I/I__I__I/I__I__I__I__I	Positive Negative

Final Diagnostics_____

Medical conduct _____

_____

Name and signature