COVID -19 Maternal & Infant Outcomes Infant Follow-Up Form

The New Jersey Department of Health (NJDOH) is investigating maternal and infant outcomes in cases of COVID-19 infection during pregnancy. This form should be used to note the findings from the infant's physical exam. The NJDOH team will coordinate additional data collection as necessary. *Please note this is a dynamic situation and this form may be modified or changed.* **Submission Instructions:** Scan and send via **secure** email to: pregnantcovid@doh.nj.gov **OR** Fax to: 609-228-5635 **OR** Mail to: COVID Pregnancy Outcomes, SCHEIS, PO Box 364, Trenton, NJ 08625-0364

Name of Person Completing Form:_____

Email or Phone #: _____ **Date completed:** _____

Medical Record # **OR** COVID CDRSS Case ID: _____

Name of Child**:** _____ DOB**:** _____

If expired, date of death**:** _____ Cause of death**:** _____

Was infant hospitalized after birth? ☐ Y ☐ N

If yes, date(s): _____
Admitting dx (ICD10 or text): _____

Did the infant have jaundice requiring phototherapy after hospitalization? ☐ Y ☐ N

Infant Well-Child Visits

	2-month visit	6-month visit
Date of visit		
Type	☐ In person ☐ Telehealth	☐ In person ☐ Telehealth
Infant/child length (cm/in)		
Infant/child weight (kg/lb & oz)		
Infant/child head circumference (cm/in)		
Is the infant receiving breastmilk (including expressed, donated, etc.)?	☐ Y ☐ N	☐ Y ☐ N
If yes:	☐ Exclusive breastmilk ☐ Breastmilk and formula ☐ Unknown	☐ Exclusive breastmilk ☐ Breastmilk and formula ☐ Unknown

COVID-19 Point of Care Results

ONLY document POC results. Results for lab-conducted tests will be determined from CDS data

☐ **Check if none or enter:**

Date: _____ **Result:**_____

Date: _____ **Result:**_____

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Did infant exhibit symptoms in the first 2 months of life that represented a *possible* or confirmed diagnosis of COVID-19?

	Date
☐ **Fever**	
☐ **Respiratory (i.e. cough, congestion)**	
☐ **Other symptoms**	
Specify:	

Referrals

☐ **Check off if none**

Check off which referral(s) was/were made at this time:

2 months visit or beforehand	After 2 months but before 6 months
☐ Early Intervention ☐ PT ☐ OT	☐ Early Intervention ☐ PT ☐ OT
☐ Speech Language Pathology	☐ Speech Language Pathology
☐ Developmental specialist	☐ Developmental specialist
☐ Medical/Surgical specialist	☐ Medical/Surgical specialist
☐Other: _____	☐Other: _____
☐ None	☐ None

Please provide details below on Ophthalmology/Audiology exams:

Ophthalmology Exam: ☐ **Check off if none**

Date	Result	If abnormal, describe:
	☐ Normal ☐ Abnormal	
	☐ Normal ☐ Abnormal	

Audiology Exam: ☐ **Check off if none**

Date	Result	If abnormal, describe:
	☐ Normal ☐ Abnormal: ☐ Unilateral ☐ Bilateral	☐ Conductive Hearing Loss ☐ Sensorineural Hearing Loss ☐ Mixed Hearing Loss ☐ Auditory Neuropathy Spectrum Disorder ☐ Hearing Loss, Type Unknown/Unspecified ☐ Other:
	☐ Normal ☐ Abnormal ☐ Unilateral ☐ Bilateral	☐ Conductive Hearing Loss ☐ Sensorineural Hearing Loss ☐ Mixed Hearing Loss ☐ Auditory Neuropathy Spectrum Disorder ☐ Hearing Loss, Type Unknown/Unspecified Other:

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Outcomes Infant Follow-Up Form

Systems

	2-month visit	6-month visit
General	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
If abnormal, describe:		
HEENT	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
If abnormal, describe:		
Cardiovascular	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
If abnormal, describe:		
Pulmonary/Lung/Respiratory	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
If abnormal, describe:		
Abdominal/GI	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
If abnormal, describe:		
Genitourinary	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
If abnormal, describe:		
Musculoskeletal	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
If abnormal, describe:		
Neurologic	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
If abnormal, describe:		
Skin/Integument	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
If abnormal, describe:		

Additional abnormal findings (0-2 mos):_____

Additional abnormal findings (3-6 mos):_____

_____