

SUSPECTED CONGENITAL SYPHILIS/SYPHILIS-EXPOSED INFANT

Date of Notification: (DD/MM/YYYY)

Date Investigation Started: (DD/MM/YYYY)

INFANTS'S DEMOGRAPHICS (Use mother's data if infant's details not yet known)

Patient's ID Type:

National Identification Number (NIN) Other Specify:

Patient's ID Number:

First Name:

Middle Name(s):

Last Name:

Pet Name(s)

Sex Assigned at Birth: Male Female

Date of Birth: (DD/MM/YYYY)

Age:

Years/Months/Weeks/Days:

Name of Facility Where Infant Seen:

Medical Record Number:

Country of Residence:

Parish (Jamaica):

House Number, Street Name:

Landmark or directions to address:

Community:

MOTHER'S INFORMATION (no need to repeat if already in demographic data above)

ID Type:

Driver's License TRN Passport NIN

Mother's ID Number:

First Name:

Middle Name(s):

Last Name:

Pet Name(s)

Mother's Maiden Name (If Applicable):

Facility where mother seen:

Medical Record Number:

House Number, Street Name:

Parish (Jamaica):

Phone Number:

Email Address:

Occupation:

Phone Number:

Name of School /Workplace:

Email Address:

Address of School/Workplace:

Marital Status:

<input type="checkbox"/> Married	<input type="checkbox"/> Visiting Union	<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated
<input type="checkbox"/> Common Law	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Other (specify):

NEXT OF KIN OF MOTHER

NOK's First Name:

NOK's Last Name:

NOK's Address: Lot/ Street/Community/Parish:

NOK's Phone number:

NOK's Email address:

CONGENITAL SYPHILIS INVESTIGATION

MEDICAL RECORD NUMBER:

PATIENTS' NAME:

MOTHER'S CLINICAL PROFILE

Was the mother tested for syphilis? Yes No Unknown

Mother's Test (Current Pregnancy)	Result	Titre	Date Test Done (DD/MM/YYYY)
Treponemal Test			
SD Bioline	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
Other Treponemal Test (e.g., TPPA, MHA-TP)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		
Non-Treponemal Test			
VDRL	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive <input type="checkbox"/> Unknown		
TRUST	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive <input type="checkbox"/> Unknown		
RPR	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive <input type="checkbox"/> Unknown		

Did mother have a syphilis test (VDRL/TRUST) done in her previous pregnancy? Yes No Unknown

Was the VDRL/TRUST result reactive in her previous pregnancy? Yes No Unknown

Was the mother treated for syphilis in previous pregnancy? Yes No Unknown

MOTHER'S MEDICATION HISTORY (including previous pregnancy)

Medication	Dose	Frequency	Route of administration	Date administered (DD/MM/YYYY)	Number of doses
<input type="checkbox"/> Benzathine penicillin G					
Dose 1					
Dose 2					
Dose 3					
<input type="checkbox"/> Other (specify):					
<input type="checkbox"/> Other (specify):					

CONGENITAL SYPHILIS INVESTIGATION

MEDICAL RECORD NUMBER:

PATIENTS' NAME:

MOTHER'S ANTENATAL HISTORY

Gravida:	Parity:
Stillbirths:	Pre-Term births:
Miscarriages:	Interview Record #:
Livebirths:	Number of living children:

LMP (DD/MM/YYYY):	EDD (DD/MM/YYYY):
Ultrasound EDD:	
Multiple Gestation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Number of foetuses:
Place of delivery:	
Did the mother have a history of vaginal discharge in mother? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Number of lifetime sex partners:	
Did the mother receive antenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Where did mother receive antenatal care? <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Both	
What is the source of primary antenatal care?	

SITE	NUMBER OF VISITS
<input type="checkbox"/> Health Centre	
<input type="checkbox"/> High Risk Clinic	
<input type="checkbox"/> General Practitioner	
<input type="checkbox"/> Obstetrician/ Gynaecologist	
<input type="checkbox"/> Other (Specify):	
TOTAL VISITS	

Date of first visit (DD/MM/YYYY):	Gestational age at first visit:
Date of last visit (DD/MM/YYYY):	Gestational age at last visit:

NAME OF SEXUAL CONTACT	AGE	SEX	RELATIONSHIP TO PATIENT OR MOTHER	CONTACT INFORMATION	SYPHILIS TEST RESULT (SPECIFY TEST AND DATE OF TEST)	TYPE OF TREATMENT GIVEN	DATE(S) TREATED (DD/MM/YYYY)
			Father of Infant				

TRACING OF SEXUAL CONTACTS OF MOTHER

CONGENITAL SYPHILIS INVESTIGATION

MEDICAL RECORD NUMBER:

PATIENTS' NAME:

Date Patient Seen (DD/MM/YYYY):

Gestational Age at Birth: Birth Outcome: Live Birth StillbirthBirth Category by Gestation: Pre-Term Term Post-TermAdmitted to Hospital? Yes No Unknown Date of Admission (DD/MM/YYYY): Date of Discharge (DD/MM/YYYY):

Hospital: Medical Record Number: Ward:

Admitting Diagnosis: Date of Diagnosis (DD/MM/YYYY):

Admitted to Special Care Nursery (SCN) or NICU: Yes No Unknown Admitted to NICU: Yes No Unknown

Date of Admission to SCN/NICU (DD/MM/YYYY): Date of Discharge from SCN/NICU (DD/MM/YYYY):

Vital Status (Outcome): Alive Dead Date of Death (DD/MM/YYYY): Time of Death: ____:____ AM/PMPlace of Death: Home DOA Ward ICU Other (Specify): _____

Signs or Symptoms	Presence	Date of Onset (DD/MM/YYYY):
Generalised lymphadenopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Vesiculo-bullous rash	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Pneumonitis/pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Neurological symptoms	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Mucous patches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Snuffles	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Anaemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Hepatosplenomegaly	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Failure to thrive	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Other (Specify):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Infant's Measurements

Measure	Value (units)	Date Measurement Taken (DD/MM/YYYY)
Birth weight		
Current weight		
Weight for age Z-score		
Birth length		
Current length		
Length for age Z-score		
Birth head circumference		
Head circumference		
Head circumference for age Z-score		
Other problem or diagnosis:	Date of Diagnosis (DD/MM/YYYY):	

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DIAGNOSTIC INVESTIGATION SCREENING FOR NEONATE/INFANT

Was a sample taken? Yes No Unsure

If yes, what specimen was taken?

Blood Sample CSF

Other, Specify: _____

What date was the specimen taken? (DD/MM/YYYY):

Which lab is the sample being sent to?

National Public Health Laboratory University of the West Indies Other

Specify Other Laboratory:

INFANT'S LABORATORY TEST RESULTS			
Test Type	Specimen Type	Date Specimen Collected (DD/MM/YYYY)	Test Result
Treponemal Tests			
SD Bioline	Blood		<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown
TPPA	Blood		<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown
Other Treponemal test (please specify)	Blood		<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown
Non-Treponemal Tests			
VDRL	Blood		<input type="checkbox"/> Non-Reactive <input type="checkbox"/> Reactive <input type="checkbox"/> Unknown Titre:
TRUST	Blood		<input type="checkbox"/> Non-Reactive <input type="checkbox"/> Reactive <input type="checkbox"/> Unknown Titre:
VDRL	CSF		<input type="checkbox"/> Non-Reactive <input type="checkbox"/> Reactive <input type="checkbox"/> Unknown
Other Test (Specify):			
Other Test (Specify):			
Other Test (Specify):			

CONGENITAL SYPHILIS INVESTIGATION

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Imaging Examination for Infant			
Study	Done	Date of Study (DD/MM/YYYY)	Findings
Long Bone X-rays	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Abdominal Ultrasound	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Other (specify):			

MEDICATION HISTORY FOR NEONATE/INFANT

Past or Current Medication	Dose	Frequency	Route of administration	Date Started (DD/MM/YYYY)	Number of doses	Duration
<input type="checkbox"/> Benzathine penicillin G						
<input type="checkbox"/> Crystalline penicillin						
<input type="checkbox"/> Other (specify):						
<input type="checkbox"/> Other (specify):						

Additional Notes on Clinical Management:

CONGENITAL SYPHILIS INVESTIGATION

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Date Investigation Completed (DD/MM/YYYY):

CLASSIFICATION

Initial Diagnosis: Congenital Syphilis

Final Diagnosis:

Case classification:

<input type="checkbox"/> Laboratory Confirmed	<input type="checkbox"/> Probable	<input type="checkbox"/> Discarded
<input type="checkbox"/> Pending	<input type="checkbox"/> Inconclusive	

Reason for classification:

DEATH CLASSIFICATION

Congenital Syphilis related death? Yes No Unknown

Immediate Cause:

Intermediate Cause:

Underlying Cause:

Comments:

Notifier's /Investigator's Details:

First Name:	Last Name
Professional Group:	
Phone number:	Email Address:
Name of Institution:	
Parish:	Community:
Investigator's Office Number/Street Name:	

Health Region: SERHA NERHA SRHA WRHA

Investigator's Signature:	Date Signed by Investigator (DD/MM/YYYY):	
Name of Parish MO(H):	Signature of MO(H):	Date signed by MO(H) (DD/MM/YYYY):