MINISTRY OF HEALTH & WELLNESS

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NATIONAL EPIDEMIOLOGY BRANCH

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:

☐ Married	☐ Visiting Union	☐ Widowed	☐ Separated
☐ Common Law	☐ Single	☐ Divorced	☐ 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	☐ Positive ☐ Negative ☐ Indeterminate		
Other Treponemal Test (e.g., TPPA, MHA-TP)	☐ Positive ☐ Negative ☐ Indeterminate		
Non-Treponemal Test			
VDRL	☐ Reactive ☐ Non-Reactive ☐ Unknown		
TRUST	☐ Reactive ☐ Non-Reactive ☐ Unknown		
RPR	☐ Reactive ☐ Non-Reactive ☐ 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
☐ Benzathine penicillin G					
Dose 1					
Dose 2					
Dose 3					
☐ Other (specify):					
☐ 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: ☐ Yes ☐ No ☐ Unknown	Number of foetuses:

Place of delivery:

Did the mother have a history of vaginal discharge in mother? ☐ Yes ☐ No ☐ Unknown

Number of lifetime sex partners:

Did the mother receive antenatal care? ☐ Yes ☐ No ☐ Unknown

Where did mother receive antenatal care? ☐ Pubic ☐ Private ☐ Both

What is the source of primary antenatal care?

SITE	NUMBER OF VISITS
☐ Health Centre	
☐ High Risk Clinic	
☐ General Practitioner	
☐ Obstetrician/ Gynaecologist	
☐ 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 ☐ Stillbirth	
Birth Category by Gestation: ☐ Pre-Term ☐ Term ☐ Post-Term		
Admitted 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/PM
Place of Death: ☐ Home ☐ DOA ☐ Ward ☐ ICU ☐ Other (Specify): _____		

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

CONGENITAL SYPHILIS INVESTIGATION

MEDICAL RECORD NUMBER:
PATIENTS' NAME:

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		☐ Negative ☐ Positive ☐ Indeterminate ☐ Unknown	
TPPA	Blood		☐ Negative ☐ Positive ☐ Indeterminate ☐ Unknown	
Other Treponemal test (please specify)	Blood		☐ Negative ☐ Positive ☐ Indeterminate ☐ Unknown	
Non-Treponemal Tests				
VDRL	Blood		☐ Non-Reactive ☐ Reactive ☐ Unknown	Titre:
TRUST	Blood		☐ Non-Reactive ☐ Reactive ☐ Unknown	Titre:
VDRL	CSF		☐ Non-Reactive ☐ Reactive ☐ Unknown	
Other Test (Specify):				
Other Test (Specify):				
Other Test (Specify):				

CONGENITAL SYPHILIS INVESTIGATION

MEDICAL RECORD NUMBER:

PATIENTS' NAME:

Imaging Examination for Infant			
Study	**Done**	**Date of Study** (DD/MM/YYYY)	**Findings**
Long Bone X-rays	☐ Yes ☐ No ☐ Unknown		
Abdominal Ultrasound	☐ Yes ☐ No ☐ 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
☐ Benzathine penicillin G						
☐ Crystalline penicillin						
☐ Other (specify):						
☐ Other (specify):						

Additional Notes on Clinical Management:

CONGENITAL SYPHILIS INVESTIGATION

MEDICAL RECORD NUMBER:
PATIENTS' NAME:

Date Investigation Completed (DD/MM/YYYY):

CLASSIFICATION

Initial Diagnosis: Congenital Syphilis

Final Diagnosis:

Case classification:

☐ Laboratory Confirmed	☐ Probable	☐ Discarded
☐ Pending	☐ 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):