MINISTRY OF HEALTH & WELLNESS

NATIONAL SURVEILLANCE UNIT, NATIONAL EPIDEMIOLOGY BRANCH,
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NATIONAL EPIDEMIOLOGY BRANCH

OPHTHALMIA NEONATORUM INVESTIGATION

Initial Diagnosis(~es): ☐ Ophthalmia neonatorum ☐ Other (Specify):

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:

CLINICAL PROFILE

Date Patient Seen (DD/MM/YYYY):

Gestational age at birth: ☐ Birth Outcome: ☐ Live Birth ☐ Stillbirth

Birth category by gestation: ☐ Pre-Term ☐ Term ☐ Post-Term

OPHTHALMIA NEONATORUM INVESTIGATION

MEDICAL RECORD NUMBER:

PATIENTS' NAME:

SIGNS OR SYMPTOMS	PRESENCE	DATE OF ONSET/DIAGNOSIS (DD/MM/YYYY)
Muco-purulent or purulent conjunctivitis	☐ Yes ☐ No ☐ Unknown	
Redness of conjunctivae and palpebrae	☐ Yes ☐ No ☐ Unknown	
Eyelids sticking together	☐ Yes ☐ No ☐ Unknown	
Oedema and swelling of eyelids	☐ Yes ☐ No ☐ Unknown	
Chemosis of conjunctivae	☐ Yes ☐ No ☐ Unknown	
Other (Specify):	☐ Yes ☐ No ☐ Unknown	
Other (Specify):	☐ Yes ☐ No ☐ Unknown	
Other (Specify):	☐ Yes ☐ No ☐ Unknown	

HOSPITAL SUMMARY

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):_____

MEDICATION HISTORY

Was the patient given any prophylaxis? Yes No Unknown

PAST OR CURRENT MEDICATION	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION	DATE OF FIRST ADMINISTRATION (DD/MM/YYYY):	NUMBER OF DOSES
☐ Silver Nitrate					
☐ Tetracycline					
☐ Ceftriaxone					
☐ Other (specify):					
☐ Other (specify):					

DIAGNOSTIC INVESTIGATION SCREENING

Was a sample taken? ☐ Yes ☐ No ☐ Unsure

If yes, what specimen was taken?

☐ Blood Sample	☐ Eye Swab
☐ 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:

OPHTHALMIA NEONATORUM INVESTIGATION

MEDICAL RECORD NUMBER:

PATIENTS' NAME:

RESULTS OF LABORATORY INVESTIGATION			
TEST TYPE	**SPECIMEN TYPE**	**DATE SPECIMEN COLLECTED** (DD/MM/YYYY)	**TEST RESULT**
GRAM STAIN			
CULTURE			
RT-PCR			
OTHER (SPECIFY):			

MOTHER'S ANTENATAL HISTORY

Gravida:	Parity:
Stillbirths:	Pre-Term births:
Livebirths:	Number of living children:

LMP (DD/MM/YYYY):	EDD (DD/MM/YYYY):
Multiple pregnancy: ☐ 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:	
TOTAL VISITS	

OPHTHALMIA NEONATORUM INVESTIGATION

MEDICAL RECORD NUMBER:
PATIENTS' NAME:

CLASSIFICATION

INITIAL DIAGNOSIS: OPHTHALMIA NEONATORUM

FINAL DIAGNOSIS:

Case classification:

☐ Laboratory Confirmed	☐ Probable/ Clinically diagnose	☐ Discarded
☐ Pending	☐ Inconclusive	

Reason for classification:

DEATH CLASSIFICATION

Ophthalmia Neonatorum related death? ☐ Yes ☐ No ☐ Unknown

Immediate Cause:

Intermediate Cause:

Underlying Cause:

Date Investigation Completed (DD/MM/YYYY):

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 ☐ SRHA ☐ WRHA ☐ NERHA

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):