Congenital Syphilis Case Investigation Form (CIF)

NB: [To be completed and submitted together with Notifiable Medical Conditions (NMC) Case Notification Form (CNF)]

Infant Information

<table>
<tr><td>1</td><td>Case Notification number</td><td colspan="3"></td></tr>
<tr><td>2</td><td>Date of notification</td><td colspan="3"></td></tr>
<tr><td>3</td><td>Date of delivery (dd/mm/yyyy)</td><td colspan="3"></td></tr>
<tr><td>4</td><td>Name and surname of infant</td><td colspan="3"></td></tr>
<tr><td>5</td><td>Patient folder number/Patient HPRS-PRN</td><td colspan="3"></td></tr>
<tr><td>6</td><td>Status of the patient</td><td colspan="3">|__| Alive
|__| Stillbirth
|__| Miscarriage
|__| Neonatal death (<28 days of life)
|__| Infant/childhood death</td></tr>
<tr><td>7</td><td>Gestational age at delivery</td><td colspan="3"></td></tr>
<tr><td>8</td><td>Birth weight or weight of fetus (if stillbirth/miscarriage)</td><td colspan="3">______ g</td></tr>
<tr><td>9</td><td>Age at syphilis test</td><td colspan="3"></td></tr>
<tr><td>10</td><td>Date of syphilis test (RPR) (dd/mm/yyyy)</td><td colspan="3"></td></tr>
<tr><td>11</td><td>Result of RPR syphilis test</td><td colspan="3">|__| Reactive |__| Non-Reactive</td></tr>
<tr><td>12</td><td>If reactive, RPR titre level (value or ratio)</td><td colspan="3"></td></tr>
<tr><td>13</td><td>Specimen barcode of syphilis test</td><td colspan="3"></td></tr>
<tr><td rowspan="4">14</td><td rowspan="4">Other syphilis tests done – Tick all that apply
Specify whether done on blood, CSF, placenta, amniotic fluid, autopsy material, exudate or body fluids
State results for each test if done</td><td>Test</td><td>Type of specimen</td><td>Result</td></tr>
<tr><td>|__| TPAb/ TPHA/ TPPA</td><td></td><td></td></tr>
<tr><td>|__| VDRL (on CSF)</td><td></td><td></td></tr>
<tr><td>|__| Fluorescent treponemal antibody – absorption test</td><td></td><td></td></tr>
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<table>
<tr><td></td><td></td><td>|__| Treponema pallidum PCR</td><td></td><td></td></tr>
<tr><td></td><td></td><td>|__| Dark field microscopy</td><td></td><td></td></tr>
<tr><td></td><td></td><td>|__| Other
Specify: ______</td><td></td><td></td></tr>
<tr><td>15</td><td>**Does the infant have features suggestive of early congenital syphilis?**

If yes tick all that apply</td><td colspan="3">|__| No clinical features suggestive of early congenital syphilis
|__|Hepatosplenomegaly
|__| Rash
|__| Jaundice
|__| Anaemia
|__| Nasal discharge
|__| Mucosal lesions
|__| Pseudoparalysis of limb/s
|__| Delayed milestones
|__| Failure to thrive
|__| Pneumonia
|__| Thrombocytopaenia
|__| Lymphadenopathy
|__| Neurological complications
|__| Other
If other, specify: ______</td></tr>
<tr><td>16</td><td>**Does the infant/ child have any radiological findings suggestive of syphilis**
If yes tick all that apply</td><td colspan="3">|__| No radiological features suggestive of early congenital syphilis
|__| Periostitis
|__| Metaphysitis
|__| Osteochondritis
|__| Osteomyelitis
|__|Other
If other, specify: _______________</td></tr>
<tr><td>17</td><td>**Treatment for syphilis received**</td><td colspan="3">|__|Yes |__| No</td></tr>
<tr><td>18</td><td>**Specify treatment for syphilis received**</td><td colspan="3">|__| crystalline penicillin G
|__| benzathine penicillin G
|__| procaine penicillin G
|__| Bicillin CR (benzathine penicillin G + procaine penicillin G)</td></tr>
</table>

		|__| Other **Specify:** ______ **Dose:** ___units/kg
19	**If no, the reason for not receiving the above listed treatment**	|__| Penicillin shortage |__| Adverse reaction to treatment |__| Stillbirth |__| Other **If other, specify:** _______
20	**Date of syphilis treatment- 1st dose received** (dd/mm/yyyy)	
21	**Number of doses received**	
22	**Duration of treatment**	_____ days
23	**Other tests done (result)**	**Please tick all that applies.** **Test results** |__| Toxoplasmosis : ……………… |__| Rubella virus : ……………… |__| CMV : ……………… |__| Herpes Simplex virus : ……………... |__| HIV :……………… |__| TB :……………….. |__| Malaria :……………….. |__| Other :……………….. **If other, specify:** ______
24	**Other relevant laboratory tests eg) LFTs**	
25	**Specimen barcode of HIV test**	

Maternal Information

1	**Name and surname of mother**	
2	**Patient folder number/Patient HPRS-PRN**	
3	**Gestational age at delivery/stillbirth/miscarriage**	_____ weeks
4	**Syphilis test done during pregnancy**	|__|Yes |__| No
5	**Date of syphilis test (RPR)** (dd/mm/yyyy)	
6	**Result of RPR syphilis test**	|__|Reactive |__| Non-Reactive
7	**If reactive, RPR titre level (value or ratio)**	

8	**Specimen barcode of booking syphilis test**	
9	**Repeat RPR test done at 32 weeks or after**	|__|Yes |__| No
10	**Date of syphilis test (RPR)** (dd/mm/yyyy)	
11	**Result of RPR syphilis test**	|__|Reactive |__| Non-Reactive
12	**If reactive, RPR titre level (value or ratio)**	
13	**Specimen barcode of syphilis test at 32 weeks**	
14	**Treatment for syphilis received**	|__|Yes |__| No
15	**Specify treatment for syphilis received**	|__| crystalline penicillin G |__| benzathine penicillin G |__| procaine penicillin G |__| Bicillin CR (benzathine penicillin G + procaine penicillin G) |__| Other **If other, specify: ______** **Dose:______** units
16	**Date of syphilis treatment 1st dose received** (dd/mm/yyyy)	
17	**Gestational age at 1st dose**	
18	**Number of syphilis treatment doses received**	
19	**HIV status**	|__| Positive |__| Negative
20	**If HIV positive, VL if available**	

Notifier Details

1	**Name of notifier**	
2	**Occupation**	
3	**Contact number**	
4	**Facility**	
5	**Sector**	|_| Private |_| Public
6	**Province**	
7	**District**	

1. Complete the NMC Case Notification Form (CNF).
2. Complete this Congenital Syphilis Case Investigation Form (CIF).
3. Send the CNF & the CIF to NMCsurveillanceReport@nicd.ac.za or fax to 086 639 1638 or NMC hotline 072 621 3805. Form(s) can be sent via sms, whatsapp, email, or fax.