**Congenital Syphilis Case Investigation Form (CIF)  
NB: To be completed and submitted together with the Notifiable Medical Conditions (NMC) Case Notification Form (CNF)**

**Infant Information**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **Case Notification number** |  |  |  |  |  |  |  |
| **2** | **Date of notification** |  |  |  | | |  |  |  |
| **3** | **Date of delivery** (dd/mm/yyyy) |  |  |  |  |  |  |  |
| **4** | **Name and surname of infant** |  | | | | | | |
| **5** | **Patient folder number/ HPRN** |  | | | | | | |
| **6** | **Status of the patient** | |\_\_| Alive  |\_\_| Stillbirth  |\_\_| Miscarriage  |\_\_| Neonatal death (<28 days of life)  |\_\_| Infant/childhood death | | | | | | |
| **7** | **Gestational age at delivery/stillbirth/miscarriage** | \_\_\_\_\_ weeks | | | | | | |
| **8** | **Birth weight or weight of fetus (if stillbirth/miscarriage)** | \_\_\_\_\_ g | | | | | | |
| **9** | **Age at syphilis test** |  | | | | | | |
| **10** | **Date of syphilis test (RPR)** (dd/mm/yyyy) |  |  |  |  |  |  |  |
| **11** | **Result of RPR syphilis test** | |\_\_| Reactive |\_\_| Non-Reactive | | | | | | |
| **12** | **If reactive, RPR titre (ratio)** |  |  |  |  |  |  |  |
| **13** | **Specimen barcode of syphilis test** |  | | | | | | |
| **14** | **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** | |  |  |  | | --- | --- | --- | | **Test** | **Type of specimen** | **Result** | | |\_\_| TPAb/ TPHA/ TPPA |  |  | | |\_\_| VDRL (on CSF) |  |  | | |\_\_| Fluorescent treponemal antibody – absorption test |  |  | | |\_\_| Treponema pallidum PCR |  |  | | |\_\_| Dark field microscopy |  |  | | |\_\_| Other **If other, specify:** |  |  | | | | | | | |
|  |  |  | | | | | | |
|  |  | |­­\_\_| No clinical features suggestive of early congenital syphilis  |\_\_| Intra-Uterine Growth Restriction | | | | | | |
|  |  | |\_\_| Hepatosplenomegaly | | | | | | |
|  |  | |\_\_| Rash  |\_\_| Rhinitis | | | | | | |
|  |  | |\_\_| Jaundice  |\_\_| Oedema  |\_\_| Lymphadenopathy | | | | | | |
| **15** | **Does the infant have features suggestive of early congenital syphilis?**  **If yes tick all that apply** | |\_\_| Anaemia  |\_\_| Thrombocytopaenia  |\_\_| Mucosal lesions  |\_\_| Pseudoparalysis of limb/s | | | | | | |
|  |  | |\_\_| Respiratory distress / Pneumonia | | | | | | |
|  |  | |\_\_| Heart murmur  |\_\_| Neurological complications  |\_\_| Failure to thrive | | | | | | |
|  |  | |\_\_| Other **If other, specify: \_\_\_\_\_\_** | | | | | | |
|  |  | |\_\_| No radiological features suggestive of early congenital syphilis | | | | | | |
|  |  | |\_\_| Periostitis | | | | | | |
| **16** | **Does the infant/ child have any radiological findings suggestive of syphilis** | |\_\_| Metaphysitis | | | | | | |
| **If yes tick all that apply** | |\_\_| Osteochondritis  |\_\_| Osteomyelitis | | | | | | |
|  |  | |\_\_|Other **If other, specify: \_\_\_\_\_\_** | | | | | | |
| **17** | **Treatment for syphilis received** | |\_\_|Yes |\_\_| No | | | | | | |
| **18** | **Specify treatment for syphilis received** | ­|\_\_| benzathine benzylpenicillin (Bicillin LA) IM  |\_\_| benzylpenicillin (Penicillin G) IV/IM  |\_\_| procaine penicillin IM  |\_\_| Bicillin CR (benzathine + procaine salts of penicillin G) IM  |\_\_| Other **If 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 / frequency** |  | | | | | | |
| **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/ HPRN** |  |
| **3** | **Booked vs unbooked pregnancy** | |\_\_| Booked |\_\_|Unbooked |
| **4** | **Syphilis test done at booking** | |\_\_|Yes |\_\_| No |
| **5** | **Date of maternal booking syphilis test** (dd/mm/yyyy) |  |
| **6** | **Rapid vs laboratory test done** | |\_\_| Rapid test |\_\_|Laboratory test |
| **7** | **Result of maternal syphilis test** | |\_\_|Reactive |\_\_| Non-Reactive |
| **8** | **RPR titre (ratio) if reactive** |  |
| **9** | **Specimen barcode of booking test** |  |
| **10** | **Repeat test done at 32–34 weeks** | |\_\_|Yes |\_\_| No |
| **11** | **Date of repeat syphilis test** (dd/mm/yyyy) |  |
| **12** | **Type of repeat test done** | |\_\_| Rapid test |\_\_|Laboratory test |
| **13** | **Result of 32–34 week syphilis test** | |\_\_|Reactive |\_\_| Non-Reactive |
| **14** | **If reactive, RPR titre level (ratio)** |  |
| **15** | **Specimen barcode of 32-34 week test** |  |
| **16** | **Syphilis test done at any other time** | |\_\_|Yes |\_\_| No |
| **17** | **Date of testing** |  |
| **18** | **Result of test at any other time** | |\_\_|Reactive |\_\_| Non-Reactive |
| **19** | **Titre at any other time** |  |
| **20** | **Treatment for syphilis received** | |\_\_|Yes |\_\_| No |
| **21** | **Specify treatment for syphilis received** | |\_\_| benzathine penicillin IM  |\_\_| Other **If other, specify: \_\_\_\_\_\_**  **Dose:**  units |
| **22** | **If no, the reason for not receiving the above listed treatment** | |\_\_| Penicillin shortage  |\_\_| Penicillin allergy - desensitization not possible  |\_\_| Other **If other, specify: \_\_\_\_\_\_\_** |
| **23** | **Date of syphilis treatment 1st dose received** (dd/mm/yyyy) |  |
| **24** | **Gestational age at 1st dose** |  |
| **25** | **Number of penicillin doses received** | |\_\_| 1 |\_\_| 2 |\_\_| 3 |
| **26** | **HIV status** | |\_\_| Positive |\_\_| Negative |
| **27** | **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.