**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:**  |  |  |

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|  |  |  |
|  |  | |­­\_\_| 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.