

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	<input type="checkbox"/> Alive <input type="checkbox"/> Stillbirth <input type="checkbox"/> Miscarriage <input type="checkbox"/> Neonatal death (<28 days of life) <input type="checkbox"/> 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	<input type="checkbox"/> Reactive <input type="checkbox"/> 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	<table border="1"> <thead> <tr> <th>Test</th> <th>Type of specimen</th> <th>Result</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> TPAb/ TPHA/ TPPA</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> VDRL (on CSF)</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Fluorescent treponemal antibody – absorption test</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Treponema pallidum PCR</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Dark field microscopy</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other If other, specify: _____</td> <td></td> <td></td> </tr> </tbody> </table>	Test	Type of specimen	Result	<input type="checkbox"/> TPAb/ TPHA/ TPPA			<input type="checkbox"/> VDRL (on CSF)			<input type="checkbox"/> Fluorescent treponemal antibody – absorption test			<input type="checkbox"/> Treponema pallidum PCR			<input type="checkbox"/> Dark field microscopy			<input type="checkbox"/> Other If other, specify: _____		
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15	<p>Does the infant have features suggestive of early congenital syphilis?</p> <p>If yes tick all that apply</p>	<p><input type="checkbox"/> No clinical features suggestive of early congenital syphilis</p> <p><input type="checkbox"/> Intra-Uterine Growth Restriction</p> <p><input type="checkbox"/> Hepatosplenomegaly</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Rhinitis</p> <p><input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Oedema</p> <p><input type="checkbox"/> Lymphadenopathy</p> <p><input type="checkbox"/> Anaemia</p> <p><input type="checkbox"/> Thrombocytopaenia</p> <p><input type="checkbox"/> Mucosal lesions</p> <p><input type="checkbox"/> Pseudoparalysis of limb/s</p> <p><input type="checkbox"/> Respiratory distress / Pneumonia</p> <p><input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> Neurological complications</p> <p><input type="checkbox"/> Failure to thrive</p> <p><input type="checkbox"/> Other If other, specify: _____</p>
16	<p>Does the infant/ child have any radiological findings suggestive of syphilis</p> <p>If yes tick all that apply</p>	<p><input type="checkbox"/> No radiological features suggestive of early congenital syphilis</p> <p><input type="checkbox"/> Periostitis</p> <p><input type="checkbox"/> Metaphysitis</p> <p><input type="checkbox"/> Osteochondritis</p> <p><input type="checkbox"/> Osteomyelitis</p> <p><input type="checkbox"/> Other If other, specify: _____</p>
17	<p>Treatment for syphilis received</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
18	<p>Specify treatment for syphilis received</p>	<p><input type="checkbox"/> benzathine benzylpenicillin (Bicillin LA) IM</p> <p><input type="checkbox"/> benzylpenicillin (Penicillin G) IV/IM</p> <p><input type="checkbox"/> procaine penicillin IM</p> <p><input type="checkbox"/> Bicillin CR (benzathine + procaine salts of penicillin G) IM</p> <p><input type="checkbox"/> Other If other, specify: _____</p> <p>Dose: ___units/kg</p>
19	<p>If no, the reason for not receiving the above listed treatment</p>	<p><input type="checkbox"/> Penicillin shortage</p> <p><input type="checkbox"/> Adverse reaction to treatment</p> <p><input type="checkbox"/> Stillbirth</p> <p><input type="checkbox"/> Other If other, specify: _____</p>
20	<p>Date of syphilis treatment- 1st dose received (dd/mm/yyyy)</p>	
21	<p>Number of doses received / frequency</p>	

14	If reactive, RPR titre level (ratio)	
15	Specimen barcode of 32-34 week test	
16	Syphilis test done at any other time	<input type="checkbox"/> Yes <input type="checkbox"/> No
17	Date of testing	
18	Result of test at any other time	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive
19	Titre at any other time	
20	Treatment for syphilis received	<input type="checkbox"/> Yes <input type="checkbox"/> No
21	Specify treatment for syphilis received	<input type="checkbox"/> benzathine penicillin IM <input type="checkbox"/> Other If other, specify: _____ Dose: _____ units
22	If no, the reason for not receiving the above listed treatment	<input type="checkbox"/> Penicillin shortage <input type="checkbox"/> Penicillin allergy - desensitization not possible <input type="checkbox"/> Other If other, specify: _____
23	Date of syphilis treatment 1 st dose received (dd/mm/yyyy)	
24	Gestational age at 1 st dose	
25	Number of penicillin doses received	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
26	HIV status	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
27	If HIV positive, VL if available	

Notifier Details

1	Name of notifier	
2	Occupation	
3	Contact number	
4	Facility	
5	Sector	<input type="checkbox"/> Private <input type="checkbox"/> 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.