Congenital Syphilis Combined Case Notification and Investigation Form (CNF/CIF)

Facility

1	**Name of facility**	
2	**Name of province**	
3	**Name of district**	
4	**Name of sub-district**	
5	**Facility Contact No**	
6	**Additional Contact No (facility)**	
7	**Notification Date: ***	|__|__|/|__|__|__|/|__|__|__|__|
8	**Notifier details**	Name: _____ Surname: _____ Contact No: _____ Email address: _____ SANC/HPCSA No: _____

Infant demographics

1	**Name and surname**	
2	**ID type**	ID |____| Passport |____|
3	**ID number**	
4	**Date of birth** (dd/mmm/yyyy)	|__|__|/|__|__|__|/|__|__|__|__|
5	**Age in days**	
6	**Patient folder number**	
7	**Patient HPRS-PRN**	

Infant Information

1	**Patient status**	**Please one all that applies.** |__| Alive |__| Still- birth |__| Miscarriage |__| Neonatal death (<28 days of life) |__| Infant/ childhood death
2	**Gestational age**	|__|__| weeks

3	**Birth Weight or weight of fetus**	|___|__|___|___|grams
4	**Age at syphilis test**	|___|___| days
5	**Date of syphilis test (RPR)** (dd/mmm/yyyy)	|___|__|/|___|___|/|___|___|___|
6	**Result of RPR syphilis test**	|___|Reactive |___| Non-Reactive
7	**If reactive RPR titre levels**	|___|__ |___|__ |
8	**Specimen details**	Was a specimen collected (for RPR)? |___|Yes |___| No
	Date of specimen collection	|___|___|/|___|___|/|___|___|___|___|
	Specimen bar code	
9	**Any other syphilis tests done** **Tick all that apply and state results**	**Please tick all that applies.** **Test results** |___|Dark field microscopy : …… |___|Fluorescent antibody detection : …… |___|VDRL (on CSF) : ……... |___|TPAb/ TPHA/ TPPA : ……... |___| Placental Histology : ……... |___| Treponema pallidum PCR : ……... |___| FTA-IgM : ……...
10	**Does the child have features suggestive of early congenital syphilis?** **If yes tick all that applies**	**Please tick all that applies.** |___| No clinical features suggestive of early congenital syphilis |___|Hepatosplenomegaly |___|Rash |___|Rhinitis/snuffles |___|Pseudoparalysis of a limb |___|Delayed milestones |___|Failure to thrive |___|Anaemia |___|Thrombocytopaenia |___|Other **Specify: _____**
11	**Does the infant/ child have any radiological findings suggestive of syphilis** **If yes tick all that applies**	**Please tick all that applies.** |___| No radiological features suggestive of early congenital syphilis |___|Osteochondritis |___| Osteomyelitis of long bones |___| Periostitis |___|Other **Specify:_____**

Medical condition and treatment details (infant)

1	**Date of CS diagnosis**	|___|___|/|__|__|__|__|/|__|__|__|__|	
2	**Treatment for syphilis received**	|___|Yes |___| No	
3	**Other tests done (result)**	**Please tick all that applies.**	**Test results**
		|___|Toxoplasmosis	: ……
		|___|Rubella virus	: ……
		|___|CMV	: ……
		|___|Herpes Simplex virus	: ……...
		|___|HIV	:……
		|___|TB	:……..
		|___|Malaria :	:……..
		|___|Other	:……..
		Specify: ……	: ……..

Maternal Information

1	**Name and surname of mother**	
2	**Mother's folder number**	
3	**Mother's HPRS-PRN**	
4	**Mother booked for ANC**	|___|Yes |___| No |___| Unknown
5	**Syphilis test done at booking**	|___|Yes |___| No |___| Unknown
	Date of maternal booking syphilis test:	|___|___|/|__|__|__|__|/|__|__|__|__|
	Booking syphilis test type	|___|Laboratory test |___| Rapid test |___| Unknown
	Result of booking RPR syphilis test	|___|Reactive |___| Non-Reactive
	If reactive, RPR titre (ratio)	
6	**Syphilis test done at 32 weeks**	|___|Yes |___| No |___| Unknown
	Date of maternal 32 weeks syphilis test:	|___|___|/|__|__|__|__|/|__|__|__|__|
	32 weeks syphilis test type	|___|Laboratory test |___| Rapid test |___| Unknown
	Result of 32 week RPR syphilis test	|___|Reactive |___| Non-Reactive
	If reactive, RPR titre (ratio)	
7	**Treatment for syphilis received**	|___|Yes |___| No
8	**Specify syphilis treatment received**	
	Syphilis treatment, dosage received	
	Date first dose received	|___|___|/|__|__|__|__|/|__|__|__|__|

	Gestational age at 1st dose	
	Number of doses received	
	If other treatment received , specify	
	If not treated, reason for no treatment	|___|Penicillin shortage |___| Penicillin allergy, de-sensitization not possible |___| Other, specify (below) _____
11	**HIV status during pregnancy**	|___|Positive |_____| Negative |___| Known positive at booking
12	**If HIV positive, latest VL if available**	

Contact information

1	**Residential address (mother/guardian)**	Country _____ Province _____ City/Town _____ Surburb _____ Address _____ _____ _____
2	**Employment status (mother/ guardian)**	|___| Employed |___| Self- employed |___| Student |___| Pensioner |___| Unemployed |___| Unknown |___| Other