

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: *	<table border="1"> <tr> <td> </td><td> </td><td>/</td><td> </td><td> </td><td>/</td><td> </td><td> </td><td> </td><td> </td> </tr> </table>			/			/				
		/			/							
8	Notifier details	Name: _____ Surname: _____ Contact No: _____ Email address: _____ SANC/HPCSA No: _____										

Infant demographics

1	Name and surname												
2	ID type	ID <table border="1"><tr><td> </td><td> </td></tr></table> Passport <table border="1"><tr><td> </td><td> </td></tr></table>											
3	ID number												
4	Date of birth (dd/mmm/yyyy)	<table border="1"> <tr> <td> </td><td> </td><td>/</td><td> </td><td> </td><td> </td><td>/</td><td> </td><td> </td><td> </td><td> </td> </tr> </table>			/				/				
		/				/							
5	Age in days												
6	Patient folder number												
7	Patient HPRS-PRN												

Infant Information

1	Patient status	Please one all that applies. <input type="checkbox"/> Alive <input type="checkbox"/> Still-birth <input type="checkbox"/> Miscarriage <input type="checkbox"/> Neonatal death (<28 days of life) <input type="checkbox"/> Infant/ childhood death				
2	Gestational age	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td> </tr> </table> weeks				

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

Medical condition and treatment details (infant)

1	Date of CS diagnosis	____/____/____
2	Treatment for syphilis received	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Other tests done (result)	<p>Please tick all that applies.</p> <p><input type="checkbox"/> Toxoplasmosis :</p> <p><input type="checkbox"/> Rubella virus :</p> <p><input type="checkbox"/> CMV :</p> <p><input type="checkbox"/> Herpes Simplex virus :</p> <p><input type="checkbox"/> HIV :</p> <p><input type="checkbox"/> TB :</p> <p><input type="checkbox"/> Malaria :</p> <p><input type="checkbox"/> Other :</p> <p>Specify: :</p>

Maternal Information

1	Name and surname of mother	
2	Mother's folder number	
3	Mother's HPRS-PRN	
4	Mother booked for ANC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
5	Syphilis test done at booking	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Date of maternal booking syphilis test:	____/____/____
	Booking syphilis test type	<input type="checkbox"/> Laboratory test <input type="checkbox"/> Rapid test <input type="checkbox"/> Unknown
	Result of booking RPR syphilis test	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive
	If reactive, RPR titre (ratio)	
6	Syphilis test done at 32 weeks	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
	Date of maternal 32 weeks syphilis test:	____/____/____
	32 weeks syphilis test type	<input type="checkbox"/> Laboratory test <input type="checkbox"/> Rapid test <input type="checkbox"/> Unknown
	Result of 32 week RPR syphilis test	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive
	If reactive, RPR titre (ratio)	
7	Treatment for syphilis received	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Penicillin shortage <input type="checkbox"/> Penicillin allergy, de-sensitization not possible <input type="checkbox"/> Other, specify (below) _____
11	HIV status during pregnancy	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Known positive at booking
12	If HIV positive, latest VL if available	

Contact information

1	Residential address (mother/guardian)	Country _____ Province _____ City/Town _____ Suburb _____ Address _____ _____ _____
2	Employment status (mother/ guardian)	<input type="checkbox"/> Employed <input type="checkbox"/> Self- employed <input type="checkbox"/> Student <input type="checkbox"/> Pensioner <input type="checkbox"/> Unemployed <input type="checkbox"/> Unknown <input type="checkbox"/> Other