

# ISOSS syphilis paediatric notification

form date 04/22

REPORTING HOSPITAL: [Pre-populated]

HOSPITAL CODE (ICH use): [Pre-populated]

## PART 1: CHILD INFORMATION

### I. Demographic details

Date of birth: ___/___/___	<input type="checkbox"/> Male or <input type="checkbox"/> Female <input type="checkbox"/> Indeterminate	Initials: .....	Soundex: .....
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NHS/CHI no.: .....

Hospital no.: .....

### Ethnic origin:

#### White

- British  
 Irish  
 Any other White background

#### Black or Black British

- Caribbean  
 African  
 Any other Black background

#### Other Ethnic Groups

- Chinese  
 Any other ethnic group

#### Mixed

- White and Black Caribbean  
 White and Black African  
 White and Asian  
 Any other mixed background

#### Asian or Asian British

- Indian  
 Pakistani  
 Bangladeshi  
 Any other Asian background

Not stated

### Place of birth:

UK – hospital of birth: .....

Home postcode (leave off last letter):

Home postcode at birth (if different from above):

### II. Pregnancy outcome

#### Exposed to other maternal infection(s)?

None  HIV  HBV  HCV

Other, specify: .....

Was a Syphilis Birth Plan used and made available for paediatric/neonatal follow-up? Yes,  BASHH Syphilis birthplan\*  local/other syphilis birthplan  No, reason: .....

\* [see BASHH Birthplan](#)

### III. Perinatal details

Other confirmed infection(s) in infant?  No  Yes, specify: .....

#### Congenital abnormalities?

No  Yes, specify: .....

Other infant problems?  None  Jaundice  Anaemia  Hydrops  Pyrexia  Limb swelling/pain

Other, specify: .....

## PART 2: DETAILS OF CHILD'S TESTING AND TREATMENT

### I. Identification and clinical presentation

#### How did the child come to medical attention?

Signs/symptoms in the child, specify: .....  Maternal illness  Antenatal screening

Other, specify: .....

### II. Laboratory investigation results

Diagnostic test results (child): \*please note that for surveillance purposes ISOSS will not seek further follow-up if RPR negative at 3 months

Type of test	Date of test	Result
RPR (birth)	___/___/___	_____
RPR (3mths)	___/___/___	_____
EIA-IgM (birth)	___/___/___	_____
EIA-IgM (3mths)	___/___/___	_____

### III. Treatment details

**Did the infant receive treatment for syphilis infection?**

- No, mother adequately treated for syphilis in pregnancy and/or infant RPR negative
- No, other.....
- Yes, benzyl penicillin     Yes, other specify: .....

**Date(s) of treatment:** \_\_\_/\_\_\_/\_\_\_ (or \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_)

- Reason(s) for treatment:**     Mother insufficiently treated in pregnancy     Clinical signs of syphilis
- Confirmed congenital syphilis (*Lab tests: Infant RPR 4x mother's, IgM +ve, Microscopy +ve, PCR +ve*)
  - Other, specify: .....

**PART 3: CHILD FOLLOW-UP**

- Still in follow-up at this unit
- Discharged (following negative RPR)
- Follow-up elsewhere, details: .....
- Lost to follow-up, details.....
- Known to have left UK
- Deceased, date of death: \_\_\_/\_\_\_/\_\_\_ & cause of death: .....

Please indicate if this is a looked after child (foster care or adopted)

**PART 4: ADDITIONAL INFORMATION**

Please enter any additional information below

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