Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Congenital Syphilis Surveillance Form v 2.0 07/07/2015

CONFIDENTIAL

hpsc

CIDR Event ID:

Section A: Patient (Child) Information

1. Patient's Hospital No.: **2.** Hospital Name:

3. Forename:
4. Surname:

5. Address:

8. Sex: ☐ Male ☐ Female

6. County:

9. Date of Birth: **10.** If multiple birth: ☐ of ☐

11. Country of birth:
12. Hospital/Place of birth:
If different from above

14. Gestational age *(completed weeks)*: /40
13. Birthweight: grams

15. Ethnicity:

White:
- ☐ Irish
- ☐ Irish Traveller
- ☐ White other

Black:
- ☐ African
- ☐ Black other

Asian:
- ☐ Chinese
- ☐ Asian other

- ☐ Unknown
- ☐ Other / Mixed ethnicity

16. If other ethnicity, please specify:

Section B: Referral Pathway

17. How did the child come to medical attention?
- ☐ Antenatal screening
- ☐ Stillbirth
- ☐ Maternal illness
- ☐ Signs/symptoms in child
- ☐ Other, please specify:

Section C: Clinical Details

18. Age at presentation: Days/ Weeks/Months/Year(s)

19. Is the patient (child) symptomatic? Yes ☐ No ☐ Unk. ☐

Please indicate symptoms:

	Yes	No	Unk.
Stillbirth	☐	☐	☐
Hepatosplenomegaly	☐	☐	☐
Mucucutaneous lesion	☐	☐	☐
Pseudoparalysis	☐	☐	☐
Nephrotic syndrome	☐	☐	☐
Central nervous involvement	☐	☐	☐

If yes, please give details:

	Yes	No	Unk.
Condyloma lata	☐	☐	☐
Anaemia	☐	☐	☐
Malnutrition	☐	☐	☐
Persistent rhinitis	☐	☐	☐
Jaundice	☐	☐	☐

If other signs/symptoms, please specify:

20. Date of diagnosis/confirmation: ***Please record laboratory results overleaf***

21. Outcome:
- ☐ No long-term sequelae
- ☐ Long term sequelae
- ☐ Died

22. If died, date of death:

Section D: Reporting Paediatrician

23. Name:

24. Contact telephone number:

25. Contact email:

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Section E: Child's laboratory results

26. Repeat PRP & TPPA Results:

Date	RPR Result	TPPA Result

27. CSF:

Date	Protein	White cell count

RPR Result	TPPA Result

Section F: Mother's details

28. Mother's Hospital No.:

29. Maternity hospital/unit:

30. Surname:

31. Forename:

32 Address:

33. County:

34. Country of birth:

35. Date of Birth:

36. Ethnicity:

White:
- Irish
- Irish Traveller
- White other

Black:
- African
- Black other

Asian:
- Chinese
- Asian other

- Unknown
- Other / Mixed ethnicity

37. If other ethnicity, please specify:

Section G: Maternal Disgnosis

38. Date of maternal syphilis diagnosis:

	Yes	No	Unknown
39. Mother diagnosed as a result of antenatal screening?			
40. Mother treated for syphilis prior to pregnancy?			
41. Mother treated for syphilis infection during pregnancy?			

If yes: Please specify therapy:

Date treatment completed

42. Stage of infection:
- Primary
- Secondary
- Early latent
- Late latent
- Latent of undetermined duration
- Tertiary
- Unknown

Section H: Comments

Please return this completed form to your local Director of Public Health - see www.hpsc.ie for details.