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|  | | | | | | | | | | | **Congenital Syphilis Enhanced Surveillance Form**  Version 5  CONFIDENTIAL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Home - Health Protection Surveillance Centre | | | | | |
| CIDR ID: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Enter text here | | | | | |
| **A. Case Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Patient Hospital No. | | | | | | | | | | | | | Enter text here | | | | | | | | | | | | | | | | | | | | |  | Hospital Name | | | | | | | | | Enter text here | | | | | | | | |  | |
|  | Forename | | | | | | | | | | | | | Enter text here | | | | | | | | | | | | | | | | | | | | |  | Surname | | | | | | | | | Enter text here | | | | | | | | |  | |
|  | Date of birth | | | | | | | | | | | | | Click to enter a date. | | | | | | | | | | | | | | | | | | | | |  | Address | | | | | | | | | Enter text here | | | | | | | | |  | |
|  | Sex | | | | | | | | | | | | | Male  Female | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | |  | |
|  | If multiple birth: | | | | | | | | | | | | | Enter text here | | | | of | | Enter text here | | |  | | | | | | | | | | | |  | County | | | | | | | | | Choose an item. | | | | | | | | |  | |
|  | Country of birth | | | | | | | | | | | | | Choose an item. | | | | | | | | | | | | | | | | | | | | |  | Gestational age | | | | | | | | | Enter text here | | | | / 40 weeks | | | | |  | |
|  | Birthweight | | | | | | | | | | | | | Enter text here | | | | | | | | | | | | | | grams | | | | | | |  | Hospital/place of birth | | | | | | | | | Enter text here | | | | | | | | |  | |
|  | Ethnicity | | | | | | | | | | | White – Irish | | | | | | | | | | | | | | | | | | | | | | | | | | Asian or Asian Irish - Chinese | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | White – Irish Traveller | | | | | | | | | | | | | | | | | | | | | | | | | | Asian or Asian Irish – Indian/Pakistani/Bangladeshi | | | | | | | | | | | | | | | |  | |
|  |  | | | | | | | | | | | White – Any other white background | | | | | | | | | | | | | | | | | | | | | | | | | | Asian or Asian Irish – Any other Asian background | | | | | | | | | | | | | | | |  | |
|  |  | | | | | | | | | | | Black or Black Irish - African | | | | | | | | | | | | | | | | | | | | | | | | | | Arabic | | | | | | | | | | | | | | | |  | |
|  |  | | | | | | | | | | | Black or Black Irish – Any | | | | | | | | | | | | | | | | | | | | | | | | | | Roma | | | | | | | | | | | | | | | |  | |
|  |  | | | | | | | | | | | Mixed background | | | | | | | | | | | | | | | | | | | | | | | | | | Other | | | | | | | | | | | | | | | |  | |
|  |  | | | | | | | | | | | Not known | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  | |
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|  | **B. Clinical Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | How did the child come to medical attention? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | Antenatal screening | | | | | | | | | | | | | | | | | | Maternal illness | | | | | | | | | | | | | | | | | Signs/symptoms in child | | | | | | | | | | | | |
|  |  | | | | | | | Stillbirth | | | | | | | | | | | | | | | | | | Other. If other, please specify | | | | | | | | | | | | | | | | | Enter text here | | | | | | | | | | |  | |
|  | Age at presentation | | | | | | | | | | | | | | Enter text here | | | | | | | | | | | | Days  Weeks  Months  Year(s) Please tick one | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Is the patient (child) symptomatic? | | | | | | | | | | | | | | | | | | | | | Yes  No  Unk | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | **If yes, please indicate symptoms:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | | | | | | | | | | | |
|  | | | | Stillbirth | | | | | | | | | | | | | | | | | Yes  No  Unk | | | | | | | | | | | | | | | | Mucocutaneous lesions | | | | | | | | | | | Yes  No  Unk | | | | | | | |
|  | | | | Hepatosplenomegaly | | | | | | | | | | | | | | | | | Yes  No  Unk | | | | | | | | | | | | | | | | Condyloma lata | | | | | | | | | | | Yes  No  Unk | | | | | | | |
|  | | | | Bony radiological changes | | | | | | | | | | | | | | | | | Yes  No  Unk | | | | | | | | | | | | | | | | Anaemia | | | | | | | | | | | Yes  No  Unk | | | | | | | |
|  | | | | Pseudoparalysis | | | | | | | | | | | | | | | | | Yes  No  Unk | | | | | | | | | | | | | | | | Malnutrition | | | | | | | | | | | Yes  No  Unk | | | | | | | |
|  | | | | Nephrotic syndrome | | | | | | | | | | | | | | | | | Yes  No  Unk | | | | | | | | | | | | | | | | Persistent rhinitis | | | | | | | | | | | Yes  No  Unk | | | | | | | |
|  | | | | Central nervous involvement | | | | | | | | | | | | | | | | | Yes  No  Unk | | | | | | | | | | | | | | | | Jaundice | | | | | | | | | | | Yes  No  Unk | | | | | | | |
|  | | | |  | | | | | If yes, please provide details | | | | | | | | | | | | | | | | | | | | Enter text here | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | | | If other signs/symptoms, please specify: | | | | | | | | | | | | | | | | | | | | | | | | | Enter text here | | | | | | | |  | | | | | | | | | | |  | | | | | | |  |
|  | | | Date of diagnosis/confirmation | | | | | | | | | | | | | | | | | | | | | | | | | | Click to enter a date. | | | | | | | | | | | | | | | Please record laboratory results overleaf | | | | | | | | | | | |
|  | | | Outcome | | | | | | | No long-term sequelae  Long-term sequelae  Died | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |
|  | | | | If died, date of death: | | | | | | | | | | | | | | | Click to enter a date. | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |
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| **C. Child’s Laboratory results** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 1) Reactive non-treponemal test - VDRL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
|  | | | | | Date – Mother | | | | | | | | Click to enter a date. | | | | | | | | | | | | | | | | | Result - Mother | | | | | | | | | | | Enter text here | | | | | | | | | | | | | |  |
|  | | | | | Date – Child | | | | | | | | Click to enter a date. | | | | | | | | | | | | | | | | | Result – Child | | | | | | | | | | | Enter text here | | | | | | | | | | |  | | |  |
|  | | | 2) Reactive non-treponemal test – RPR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
|  | | | | | Date – Mother | | | | | | | | Click to enter a date. | | | | | | | | | | | | | | | | | Result - Mother | | | | | | | | | | | Enter text here | | | | | | | | | | |  | | |  |
|  | | | | | Date - Child | | | | | | | | Click to enter a date. | | | | | | | | | | | | | | | | | Result - Child | | | | | | | | | | | Enter text here | | | | | | | | | | |  | | |  |
|  | | | 3) Demonstration of treponemes – by DFA-TP or immunohistochemistry | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | Date | | | | | | | | Click to enter a date. | | | | | | | | | | | | | | | | | Specimen | | | | | | | | | | Umbilical cord | | | | | | Nasal discharge | | | | | Placenta | | | | |
|  | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | Autopsy material | | | | | | Skin lesion material | | | | |  | | | | |
|  | | | 4) Detection of T. pallidum nucleic acid by PCR | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | |  | | | | |  | | | | |
|  | | | | | Date | | | | | | | | Click to enter a date. | | | | | | | | | | | | | | | | | Specimen | | | | | | | | | | Umbilical cord | | | | | | Body fluids | | | | | Placenta | | | | |
|  | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | | | | | | | Autopsy material | | | | | | Exudate from suspicious materials | | | | | | | | | |
|  | | | 5) Failure to demonstrate loss of maternal TPPA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | Date | | | | | | | | Click to enter a date. | | | | | | | | | | | | | | | | | Result | | | | | | | | | | | Enter text here | | | | | | | | | |  | | |  | |
|  | | | | | Date | | | | | | | | Click to enter a date. | | | | | | | | | | | | | | | | | Result | | | | | | | | | | | Enter text here | | | | | | | | | |  | | |  | |
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| **D. Mother’s details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Mother’s Hospital No. | | | | | | | | | | | | | | | Enter text here | | | | | | | | | | | | | | | Maternity hospital/unit | | | | | | | | | | | | | Enter text here | | | | | | |  | | | |
|  | | Surname | | | | | | | | | | | | | | | Enter text here | | | | | | | | | | | | | | | Address | | | | | | | | | | | | | Enter text here | | | | | | |  | | | |
|  | | Forename | | | | | | | | | | | | | | | Enter text here | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | |
|  | | Country of birth | | | | | | | | | | | | | | | Choose an item. | | | | | | | | | | | | | | | County | | | | | | | | | | | | | Choose an item. | | | | | | |  | | | |
|  | | Date of birth | | | | | | | | | | | | | | | Click to enter a date. | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | |  | | | |
|  | | Ethnicity | | | | | | | | | | | | | White – Irish | | | | | | | | | | | | | | | | | | | | | | | | Asian or Asian Irish - Chinese | | | | | | | | | | | | |  | | | |
|  | |  | | | | | | | | | | | | | White – Irish Traveller | | | | | | | | | | | | | | | | | | | | | | | | Asian or Asian Irish – Indian/Pakistani/Bangladeshi | | | | | | | | | | | | |  | | | |
|  | |  | | | | | | | | | | | | | White – Any other white background | | | | | | | | | | | | | | | | | | | | | | | | Asian or Asian Irish – Any other Asian background | | | | | | | | | | | | |  | | | |
|  | |  | | | | | | | | | | | | | Black or Black Irish - African | | | | | | | | | | | | | | | | | | | | | | | | Arabic | | | | | | | | | | | | |  | | | |
|  | |  | | | | | | | | | | | | | Black or Black Irish – Any | | | | | | | | | | | | | | | | | | | | | | | | Roma | | | | | | | | | | | | |  | | | |
|  | |  | | | | | | | | | | | | | Mixed background | | | | | | | | | | | | | | | | | | | | | | | | Other | | | | | | | | | | | | |  | | | |
|  | |  | | | | | | | | | | | | | Not known | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | |
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|  | | **E. Maternal diagnosis** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
|  | | Date of maternal syphilis diagnosis | | | | | | | | | | | | | | | | | | | | | | Click to enter a date. | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | |
|  | | Mother diagnosed as a result of antenatal screening? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | | | | | | | | | | | | | | | |  | | |
|  | | Mother treated for syphilis prior to pregnancy? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | | | | | | | | | | | | | | | |  | | |
|  | | Mother treated for syphilis infection during pregnancy? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes  No  Unknown | | | | | | | | | | | | | | | | | | |  | | |
|  | |  | | | | If yes, please specify therapy | | | | | | | | | | | | | | | | | | | Enter text here | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
|  | |  | | | | If yes, date treatment completed | | | | | | | | | | | | | | | | | | | Click to enter a date. | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | |
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|  | | Stage of infection | | | | | | | | | | | | Early infectious syphilis | | | | | | | | | | | | | | | | | Late syphilis | | | | | | | | | | | | | | | | Unknown stage of infection | | | | | |  | | |
|  | |  | | | | | | | | | | | | Primary | | | | | | | | | | | | | | | | | Late latent | | | | | | | | | | | | | | | | Unknown | | | | | |  | | |
|  | |  | | | | | | | | | | | | Secondary | | | | | | | | | | | | | | | | | Latent of undetermined duration | | | | | | | | | | | | | | | | | | | | | |  | | |
|  | |  | | | | | | | | | | | | Early latent | | | | | | | | | | | | | | | | | Tertiary | | | | | | | | | | | | | | | |  | | | | | |  | | |
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|  | | **F. Comments** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
|  | | Enter text here | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
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|  | | **G. Reporting paediatrician** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
|  | | Name | | | | | | | | | | | | | | Enter text here | | | | | | | | | | | | | | | | | Contact telephone number | | | | | | | | | | | | | | Enter text here | | | | | |  | | |
|  | | Contact email | | | | | | | | | | | | | | Enter text here | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | |  | | |
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Please return the completed form to your local Department of Public Health.

See <http://www.hpsc.ie/NotifiableDiseases/Whotonotify/> for names and contact details. If sending by post, please place form in a sealed envelope marked “Private and Confidential”.