

CONGENITAL SYPHILIS CASE INVESTIGATION WORKSHEET

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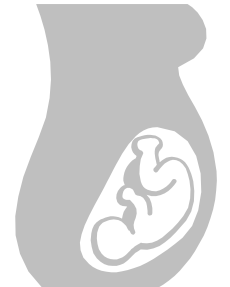
PART I – MATERNAL INFORMATION

1. Mother's Name: _____ 2. Med. Record No: _____ 3. Mother's Country of Birth: _____
 4. Street Address: _____ | Apt. No. _____ 5. ZIP Code: _____ 6. Phone No: (____) _____
 7. Delivery Hospital: _____ 8. Mother's Physician: _____ 9. Physician's Phone No: (____) _____
 10. Mother's DOB: ____/____/____ Unk 11. Mother's Age: _____ 12. Was Mother Homeless or Housing Insecure During Pregnancy? Yes No Unk
 13. Race: American Indian/Alaskan Native African American/Black Caucasian/White Asian Native Hawaiian/Pacific Islander Other Unk
 14. Ethnicity: Hispanic/Latino Not Hispanic/Latino Unk 15. Marital Status: Single/Never Married Married Separated/Divorced Widowed Unk
 16. Mother's Obstetric History: G _____ P _____ (G = pregnancies | P = live births) 17. Last Menstrual Period (LMP) Before Delivery: ____/____/____ Unk
 18a. Did Mother Have Prenatal Care? Yes No Unk (If No or Unk, go to No. 21) 18b. Number of Prenatal Care Visits: _____ Unk
 19a. Date of First Prenatal Care Visit: ____/____/____ Unk 19b. Indicate Trimester of First Prenatal Visit: First Second Third Unk
 20a. Prenatal Care Provider: _____ 20b. Facility: _____ 20c. Phone Number: (____) _____
 21. Mother's Health Insurance Status: Medicaid Private (HMO/PPO) SSDI Medicare None Unk Other _____
 22. Did Mother Have a Non-Treponemal or Treponemal Test at: (a) First Prenatal Visit? Yes No Unk (b) 28-32 Weeks Gestation? Yes No Unk
 (c) Delivery or Within Three Days of Delivery? Yes No Unk
 23. Indicate Dates and Results of (a) First and (b) Most Recent NON-TREPONEMAL Tests During Pregnancy and at Delivery ▼

DATE	RESULT	TITER
(a) ____/____/____ <input type="checkbox"/> Unk <input type="checkbox"/> No Test	<input type="checkbox"/> Reactive <input type="checkbox"/> NR <input type="checkbox"/> Unk	1:
(b) ____/____/____ <input type="checkbox"/> Unk <input type="checkbox"/> No Test	<input type="checkbox"/> Reactive <input type="checkbox"/> NR <input type="checkbox"/> Unk	1:

24. Indicate Dates and Results of (a) First and (b) Most Recent TREPONEMAL Tests During Pregnancy and at Delivery ▼

DATE	TEST TYPE	RESULT
(a) ____/____/____ <input type="checkbox"/> Unk <input type="checkbox"/> No Test	<input type="checkbox"/> EIA/CLIA <input type="checkbox"/> FTA-ABS <input type="checkbox"/> MHA-TP <input type="checkbox"/> TP-PA <input type="checkbox"/> Other <input type="checkbox"/> Unk	<input type="checkbox"/> Reactive <input type="checkbox"/> NR <input type="checkbox"/> Unk
(b) ____/____/____ <input type="checkbox"/> Unk <input type="checkbox"/> No Test	<input type="checkbox"/> EIA/CLIA <input type="checkbox"/> FTA-ABS <input type="checkbox"/> MHA-TP <input type="checkbox"/> TP-PA <input type="checkbox"/> Other <input type="checkbox"/> Unk	<input type="checkbox"/> Reactive <input type="checkbox"/> NR <input type="checkbox"/> Unk



25. Did Mother Have Darkfield or Direct Fluorescent Antibody (DFA) Exam of Lesions at Delivery? Yes—Pos Yes—Neg No Test of Lesion No Lesion Unk
 26. What was Mother's HIV Status During Pregnancy? Pos Neg Equivocal Not Tested Unk
 27a. Did Mother Have Any Signs/Symptoms of Syphilis? Yes No Unk 27b. If Yes, Specify: Lesion Rash Mucous Patches Condyloma Lata Alopecia
 28. What was Mother's Stage of Syphilis During Pregnancy? 1° 2° Early (Non 1°/Non 2°) Late/Late Latent Previously Treated/Serofast Other Unk
 29. Before This Delivery, When was Mother's Last Treated for Syphilis? Before Pregnancy During Pregnancy < 30 Days Before Delivery No Treatment Unk
 30a. If Treated, First Dose of Treatment Most Recent to Delivery ▼

TREATMENT	DATE STARTED	TREATMENT	DATE STARTED
<input type="checkbox"/> Benzathine Penicillin G (Bicillin) 2.4 million units IM single dose	____/____/____	<input type="checkbox"/> Doxycycline 100 mg PO BID >>> <input type="checkbox"/> x 14 days <input type="checkbox"/> x 28 days	____/____/____
<input type="checkbox"/> Benzathine Penicillin G (Bicillin) 2.4 million units IM x 2 weeks	____/____/____	<input type="checkbox"/> Erythromycin 500 mg PO QID x 14 days	____/____/____
<input type="checkbox"/> Benzathine Penicillin G (Bicillin) 2.4 million units IM x 3 weeks	____/____/____	<input type="checkbox"/> Tetracycline 500 mg PO QID x 14 days	____/____/____

- 30b. Indicate Trimester Mother Received First Dose of Treatment: Before Pregnancy First Second Third No Treatment Unk
 31a. Mother's Toxicology Results: Pos Neg Unk 31b. If Pos, Specify: Cannabinoids Cocaine Opioids Methamphetamines Other _____
 32. Did Mother Exchange Sex for Drugs/Money During Pregnancy? Yes No Unk 33. Was Mother Incarcerated During the Past 12 Months? Yes No Unk

PART II – INFANT/CHILD INFORMATION

34. Infant/Child's Name: _____ 35. Delivery Date: ____/____/____ Unk 36. Delivery Type: Singleton Twin > 2 Unk
 37. Gender: Male Female Unk 38. Vital Status: Born Alive Born Alive—Then Died Stillborn Unk 39. If Died, Date of Death: ____/____/____
 40. Birth Weight (in grams): _____ Unk 41. Estimated Gestational Age (in weeks): _____ Unk 42. Birth Cert. No: _____
 43. Med. Record No: _____ 44. Physician: _____ 45. Physician's Phone No: (____) _____
 46a. Infant's Toxicology Results: Pos Neg Unk 46b. If Pos, Specify: Cannabinoids Cocaine Opioids Methamphetamines Other _____
 47a. Did Infant/Child Have Reactive Non-Treponemal Syphilis Test? Yes No Unk 47b. If Yes, 1st Reactive Test Date: ____/____/____ Unk 46c. Titer: 1: _____
 48a. Any Signs of Congenital Syphilis in Infant/Child < 2 Years of Age? Yes No—Asymptomatic Unk
 48b. If Yes, Specify: Condyloma Lata Snuffles Pseudoparalysis Edema (nephrotic syndrome and/or malnutrition)
 Hepatosplenomegaly Syphilitic Skin Rash Syphilitic Hepatitis Other _____ Unk
 49. Infant/Child Evaluation ▼

TEST	DATE	RESULT	TEST	DATE	RESULT
<input type="checkbox"/> Long Bone X-Rays <input type="checkbox"/> No Test	____/____/____		<input type="checkbox"/> Treponemal (EIA/FTA-ABS/TP-PA) <input type="checkbox"/> No Test	____/____/____	
<input type="checkbox"/> CSF-WBC (cells/μL) Protein (mg/dL) <input type="checkbox"/> No Test	____/____/____		<input type="checkbox"/> Darkfield Exam of Lesions <input type="checkbox"/> No Test	____/____/____	
<input type="checkbox"/> CSF-VDRL <input type="checkbox"/> No Test	____/____/____		<input type="checkbox"/> Other (Specify): _____	____/____/____	

50. Did the Infant/Child, Placenta, or Cord Have Darkfield Exam, DFA, or Special Stains? Yes—Pos Yes—Neg No Lesions/Tissue to Test No Test Unk
 51. Was Infant/Child Treated? Yes No (If Yes, Indicate Treatment Below) ▼

TREATMENT	DATE	TREATMENT	DATE
<input type="checkbox"/> Aqueous Crystalline Penicillin G IV x 10 Days (50,000 units/kg/dose)	____/____/____	<input type="checkbox"/> Benzathine Penicillin G IM in a Single Dose (50,000 units/kg/dose)	____/____/____
<input type="checkbox"/> Procaine Penicillin G IM x 10 Days (50,000 units/kg/dose)	____/____/____	<input type="checkbox"/> Other Treatment (Specify): _____	____/____/____

52. CASE DETERMINATION: NOT A CASE CONFIRMED CASE SYPHILITIC STILLBIRTH PROBABLE CASE