**CONFIDENTIAL**

**Your ref:** [Pre-populated] **EDD:** [Pre-populated] **Hospital of delivery: ……**……………………………..

**ISOSS syphilis antenatal screen positive outcome**

***form date 06/20***

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| --- | --- | --- |
| **PART 1: CHILD INFORMATION** | | |
| 1. **Pregnancy outcome** | | |
| **Livebirth** or  **Stillbirth**  If twins\*, tick here:  \*Please give details of second twin overleaf | **Date of birth:** **\_\_\_\_/\_\_\_\_/\_\_\_\_** | **Male** or  **Female** |
| **Gestational age:** ……….. weeks | **Birthweight:** ………... kg |
| **Hospital no.:** …………………………….  **NHS/CHI no.:** …………………………… | **Congenital anomalies?**  No  Yes: …………………………………………..  **Perinatal infections?** (please inform us if Covid-19 has been suspected or diagnosed in the pregnancy)  No  Yes: ………………………………  …………………………………………………………………………………………..  **Admitted to Neonatal Unit?**  No  Yes: ……………………………………..  ………………………………………………………………………………………….. | |
| 1. **Child follow-up** | | |
| **Infant requires paediatric follow-up?**  Yes (infant requires treatment and/or testing for possible syphilis infection) **Paediatrician** ………………………..  No, reason ………………………..………………………..………………………..………………………..……………………  Not known, reason ………………………..………………………..………………………..………………………..………… | | |
| **PART 2: DELIVERY DETAILS** | | |
| **Postcode at delivery (leave off last letter):** □□□□ □□■ | | |
| **Mode of delivery:**  Vaginal  ELCS, reason: ……………………………………...  EmCS, reason: …………………………………….. | | |
| **Was BASHH Syphilis Birth Plan\* used?**   No  Yes  Not known  \* see https://www.bashhguidelines.org/media/1196/syphillis-bp\_print\_2016\_p3.pdf | | |
| **PART 3: TREATMENT DURING PREGNANCY** | | |
| Maternal treatment for syphilis infection reported on notification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Did the mother receive any treatment in addition to the above during pregnancy (for syphilis infection)?**  No  Yes, specify: ……………………………………………………………………………………...................................  **Date(s) of treatment:** \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_ (or \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_) | | |
| **PART 4: ADDITIONAL INFORMATION** | | |
| <Complete as necessary> | | |

**Please complete parts 5-6 in the case of a twin pregnancy.**

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| **PART 5: CHILD INFORMATION FOR SECOND TWIN** | | |
| 1. **Pregnancy outcome** | | |
| **Livebirth** or  **Stillbirth** | **Date of birth:** **\_\_\_\_/\_\_\_\_/\_\_\_\_** | **Male** or  **Female** |
| **Gestational age:** ……….. weeks | **Birthweight:** ………... kg |
| **Hospital no.:** ……………………………..  **NHS/CHI no.:** ……………………………. | **Congenital anomalies?**  No  Yes: …………………………………………..  **Perinatal infections?** (please inform us if Covid-19 has been suspected or diagnosed in the pregnancy)  No  Yes: ………………………………  …………………………………………………………………………………………..  **Admitted to Neonatal Unit?**  No  Yes: ……………………………………..  ………………………………………………………………………………………….. | |
| 1. **Child follow-up** | | |
| **Infant requires paediatric follow-up?**  Yes (infant requires treatment and/or testing for possible syphilis infection) **Paediatrician** ………………………..  No, reason ………………………..………………………..………………………..………………………..……………………  Not known, reason ………………………..………………………..………………………..………………………..………… | | |
| **PART 6: AND ADDITIONAL INFORMATION FOR SECOND TWIN** | | |
| <Complete as necessary> | | |