**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> |