ISOSS syphilis antenatal screen positive notification

form date 07/20

CONFIDENTIAL

HOSPITAL NAME:	HOSPITAL CODE:

PART 1: MATERNAL DETAILS

I. Demographic information

Date of birth: ____/____/____ | **Soundex:** ……

NHS/CHI no.: …… | **Hospital no.:** ……

Ethnic origin:

White
☐ British
☐ Irish
☐ Any other White background

Black or Black British
☐ Caribbean
☐ African
☐ Any other Black background

Other Ethnic Groups
☐ Chinese
☐ Any other ethnic group

Mixed
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any other mixed background

Asian or Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Any other Asian background

☐ Not stated

Home postcode (leave off last letter): ☐☐☐☐ ☐☐■

Country of birth: …… **If country of birth not UK, date of arrival:** ____/____/____

II. Social circumstances

Employment status at booking: ☐ Employed (full or part-time) ☐ Home ☐ Sick ☐ Student ☐ Unemployed ☐ Retired ☐ Voluntary ☐ Not known

Main support during pregnancy: ☐ Partner (cohabiting) ☐ Partner (not cohabiting) ☐ Family/friend ☐ Other ☐ None ☐ Not known

Employment status at booking: : ☐ Employed (full or part-time) ☐ Home ☐ Sick ☐ Student ☐ Unemployed ☐ Retired ☐ Voluntary ☐ Not known ☐ N/A (no partner)

Any documented social/complicating issues (tick all that apply)?

☐ Housing concerns ☐ Intimate partner violence ☐ Drug or alcohol misuse ☐ Mental health issues
☐ Immigration problems ☐ Prison ☐ Sex work ☐ Social services involvement ☐ None
☐ Other, details: ……
……

Does the woman speak English? ☐ No ☐ Yes
If yes, is English her first language? ☐ No ☐ Yes
Were translation services required? ☐ No ☐ Yes*
***If yes, was an interpreter used?** ☐ Yes, independent person (phone or present in the room)
☐ Yes, other: …… ☐ No, interpreter not available ☐ Not known

III. Obstetric history

Previous pregnancies
…….. **livebirth(s)**, date(s) if known: _____ …….. **stillbirth(s)** …….. **miscarriage(s)/TOP(s)**

PART 2: PREGNANCY AND ANTENATAL CARE DETAILS

Date first presented for antenatal care: ____/____/____ | **Date booked for antenatal care:** ____/____/____

Estimated date of delivery: ____/____/____ and/or **LMP:** ____/____/____

Pregnancy status:
☐ Continuing to term
☐ Miscarriage* – date: ____/____/____ at …….. weeks gestation
☐ Termination* – date: ____/____/____ at …….. weeks gestation
*If miscarriage or termination, any congenital abnormality? ☐ No ☐ Yes: ……

PART 3: ANTENATAL SYPHILIS SCREENING

Date of first positive syphilis lab test result: ____/____/____

Date first seen by screening coordinator/screening team: ____/____/____ See Screening Standard IDPS-S05 (referral: timely assessment of screen positive and known positive women

If more than 10 working days between positive lab result and screening appointment, reason: ……..
……

Diagnostic test results (mother):

Type of test	Date of test	Result				
		positive	negative	equivocal	insufficient sample	
EIA	____/____/____	☐	☐	☐	☐	
EIA-IgM	____/____/____	☐	☐	☐	☐	
TPPA	____/____/____	☐	☐	☐	☐	Titre: _____
TPHA	____/____/____	☐	☐	☐	☐	
RPR/VDRL	____/____/____	☐	☐	☐	☐	Titre: _____
Other (specify): _____	____/____/____	☐	☐	☐	☐	Titre: _____
Other (specify): _____	____/____/____	☐	☐	☐	☐	Titre: _____

NB: additional results can be added in part 6 if more space required.

PART 4: GUM MANAGEMENT

Referral made to GUM? ☐ Yes ☐ No, reason: ……
Date first seen at GUM: ____/____/____ **Clinic name:** ……

Sexual health screening test in this pregnancy?* ☐ No ☐ Yes, 1st screen date this pregnancy: ____/____/____
*this includes full sexual health screen or other testing

Concurrent maternal infection(s)? *please inform us if Covid-19 has been suspected/diagnosed in the pregnancy
☐ None ☐ HBV ☐ HCV ☐ HIV ☐ Other*, specify: ……

Clinical symptoms present upon examination? ☐ No ☐ Yes, specify: ……..
……

Did the mother receive treatment for syphilis infection during pregnancy? ☐ No, previously adequately treated ☐ No, other reason* ☐ Yes, specify: ……..
Date(s) of treatment: ____/____/____; ____/____/____; ____/____/____ (or ____/____/____ to ____/____/____)
*If no, details: ……

PART 5: DELIVERY FOLLOW-UP INFORMATION

Syphilis screen positive breakdown
☐ **Newly diagnosed** syphilis infection **requiring treatment**
☐ **Previously diagnosed** syphilis infection **requiring treatment**
☐ **Previously diagnosed** syphilis infection not **requiring treatment**
☐ Other treponemal infections ☐ Other, please specify……
False positive result ☐ (please complete parts 4 & 5) Date false positive established ____/____/____;

Will the BASHH Syphilis Birth Plan* be used? ☐ Yes ☐ No, reason……
* see BASHH Birthplan

PART 6: ADDITIONAL INFORMATION

Form completed by: Name: _____ Date: ____/____/____

Position: _____ Telephone: _____ Email: _____