

# ISOSS syphilis antenatal screen positive notification

form date 04/23

## CONFIDENTIAL

HOSPITAL NAME:

HOSPITAL CODE:

### PART 1: MATERNAL DETAILS

#### I. Demographic information

Date of birth: \_\_\_/\_\_\_/\_\_\_

Soundex: .....

NHS/CHI no.: .....

Hospital no.: .....

Is the woman registered with a GP? Yes  No

Gender the same as when registered at birth?

Yes F,  No M,  No non-binary,  No - other

#### 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, please state.....

##### 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: \_\_\_/\_\_\_/\_\_\_

- Exact date/year not known, timing:  during pregnancy (date not known)  <1 year prior to pregnancy  
 1-5 years prior to pregnancy  5-10 years prior to pregnancy  >10 years prior to pregnancy

#### 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/domestic abuse  Drug or alcohol misuse  
 Mental health issues  Immigration issues (incl. refugee/asylum seeker)  Prison  Sex work  
 Social services involvement/safeguarding  Learning difficulties  
 Not engaging with healthcare services  Financial concerns (incl accessing foodbank)  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 when screening result given?  Yes

No, reason: .....

Which language did the woman require translation services for? .....

#### III. Obstetric history

Gravida..... Parity.....+..... Date(s) of previous livebirths if known: \_\_\_\_\_

Obstetric history not known

### PART 2: PREGNANCY AND ANTENATAL CARE DETAILS

Woman known to have booked at another hospital in this pregnancy?  No  Yes, details .....

Woman known to be transferring her pregnancy care to another hospital?  No  Yes, details .....

Date booked for antenatal care at your hospital: \_\_\_/\_\_\_/\_\_\_  Unbooked (arrived in labour)

Was there a delay to the woman being booked  No  Yes, reason .....

Maternal weight at booking ..... kg      maternal height at booking ..... cm
Is this an IVF pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not known
Estimated date of delivery (by ultrasound): ____/____/____
<b>Pregnancy status:</b> <input type="checkbox"/> Continuing to term <input type="checkbox"/> Miscarriage* – date: ____/____/____ at ..... weeks gestation <input type="checkbox"/> Termination* – date: ____/____/____ at ..... weeks gestation *If miscarriage or termination, any congenital abnormality? <input type="checkbox"/> No <input type="checkbox"/> Yes: .....
<b>PART 3: ANTENATAL SYPHILIS SCREENING</b>
Was IDPS screening offered and accepted for <b>all</b> infections? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason.....
Date screening sample taken: ____/____/____
Was HIV diagnosis a result of the IDPS screening? <input type="checkbox"/> Yes <input type="checkbox"/> No, details.....
Date first seen by a member of the screening team: ____/____/____
<b>Was the result given to the woman within 5 working days?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, <a href="#">See Screening Standard IDPS-S05 (referral: timely assessment of screen positive and known positive women)</a> reason: .....
Was this appointment: face to face <input type="checkbox"/> virtual via phone <input type="checkbox"/> virtual other <input type="checkbox"/> , details.....
Previously screened negative in <i>this</i> pregnancy? <input type="checkbox"/> date of screen negative result ____/____/____
Referral made to Sexual Health? <input type="checkbox"/> Yes <input type="checkbox"/> No, reason: .....
<b>If not referred, is woman already under care of Sexual Health for this syphilis result?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, If no, who assessed that a referral to Sexual Health services was not required?.....
<b>PART 4: SEXUAL HEALTH SERVICES MANAGEMENT</b>
Date of sexual health assessment: ____/____/____
<b>Syphilis screen positive breakdown</b> <input type="checkbox"/> Newly diagnosed syphilis infection requiring treatment <input type="checkbox"/> Previously diagnosed syphilis infection requiring treatment <input type="checkbox"/> Previously diagnosed syphilis infection not requiring treatment <input type="checkbox"/> Other treponemal infections <input type="checkbox"/> Other, please specify.....
Concurrent maternal infection(s)? <input type="checkbox"/> None <input type="checkbox"/> HBV <input type="checkbox"/> HCV <input type="checkbox"/> HIV <input type="checkbox"/> Other, specify:.....
Clinical symptoms present upon examination? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify: .....
<b>Did the mother receive treatment for syphilis infection during pregnancy?</b> <input type="checkbox"/> No, previously adequately treated <input type="checkbox"/> No, other reason, details..... <input type="checkbox"/> Yes, benzathine penicillin <b>Date(s) of treatment:</b> ____/____/____; ____/____/____; ____/____/____ <input type="checkbox"/> Yes, other please specify..... <b>Date(s) of treatment:</b> ( ____/____/____ to ____/____/____)
<b>Penicillin allergy?</b> <input type="checkbox"/> If yes, referred to allergy services and appropriate treatment given after advice: <input type="checkbox"/> yes <input type="checkbox"/> no, reason.....
<b>Will a birth plan be used?</b> Yes, <input type="checkbox"/> BASHH Syphilis birthplan* <input type="checkbox"/> local/other syphilis birthplan <input type="checkbox"/> No, reason..... * <a href="#">see BASHH Birthplan</a>
<b>PART 5: ADDITIONAL INFORMATION</b>
Please enter any additional information in the space below