ISOSS syphilis antenatal screen positive notification

form date 06/23

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) ☐ <1year prior to pregnancy ☐ 1-5 years prior to pregnancy ☐ 5-10years prior to pregnancy ☐ >10years 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/detention centre ☐ 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? ☐ Yes ☐ No ☐ Not known

Estimated date of delivery (by ultrasound): ____/____/____

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

PART 3: ANTENATAL SYPHILIS SCREENING

Was IDPS screening offered and accepted for <u>all</u> infections? ☐ Yes ☐ No, reason……

Date screening sample taken: ____/____/____

Was syphilis diagnosis a result of the IDPS screening? ☐ Yes ☐ No, details……

Date first seen by a member of the screening team: ____/____/____

Was the result given to the woman within 5 working days? ☐ Yes ☐ No, See Screening Standard IDPS-S05 (referral: timely assessment of screen positive and known positive women)

reason: ……
Was this appointment: face to face ☐ virtual via phone ☐ virtual other ☐, details……..

Previously screened negative in *this* pregnancy? ☐ date of screen negative result ____/____/____

Referral made to Sexual Health? ☐ Yes ☐ No, reason: ……
If not referred, is woman already under care of Sexual Health for this syphilis result? ☐ Yes ☐ No,
If no, who assessed that a referral to Sexual Health services was not required?……

PART 4: SEXUAL HEALTH SERVICES MANAGEMENT

Date of sexual health assessment: ____/____/____

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……

Concurrent maternal infection(s)? ☐ 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, details……
☐ Yes, benzathine penicillin **Date(s) of treatment:** ____/____/____; ____/____/____; ____/____/____
☐ Yes, other please specify…… **Date(s) of treatment:** (____/____/____ to ____/____/____)
Penicillin allergy? ☐ If yes, referred to allergy services and appropriate treatment given after advice: ☐ yes ☐ no, reason……..

Will a birth plan be used? Yes, ☐ BASHH Syphilis birthplan* ☐ local/other syphilis birthplan ☐ No, reason…… * see BASHH Birthplan

PART 5: ADDITIONAL INFORMATION

Please enter any additional information in the space below