**CONFIDENTIAL**

HOSPITAL NAME: …………………………………………….. HOSPITAL CODE: …………………………………………..

HOSP

**ISOSS syphilis antenatal screen positive notification**

***form date 07/21***

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| **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  ***Mixed***  White and Black Caribbean  White and Black African  White and Asian  Any other mixed background | ***Black or Black British***  Caribbean  African  Any other Black background  ***Asian or Asian British***  Indian  Pakistani  Bangladeshi  Any other Asian background | | | | ***Other Ethnic Groups***  Chinese  Any other ethnic group  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  Learning difficulties  Not engaging with healthcare services  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: ………………………………………………………………………………………………… | | | | | | |
| 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 referral received by maternity:** \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | **Date booked for antenatal care:** \_\_\_\_/\_\_\_\_/\_\_\_\_  Unbooked (arrived in labour) | | | |
| **Maternal weight at booking** ………... kg **maternal height at booking** ………... cm | | | | | | |
| **Is this an IVF pregnancy?**  Yes  No Not known | | | | | | |
| **Estimated date of delivery:** \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | |
| **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](https://www.gov.uk/government/publications/infectious-diseases-in-pregnancy-screening-programme-standards)  If more than 10 working days between positive lab result and screening appointment, reason: ………………….  ……………………………………………………………………………………………………………………………………………  Previously screened negative in ***this*** pregnancy?  date of screen negative result \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | |
| **PART 4: SEXUAL HEALTH SERVICES MANAGEMENT** | | | | | | |
| **Referral made to Sexual Health?**  Yes  No, reason: …………………………………………………………………  If not referred, is woman already under care of Sexual Health? Yes  No,  If no, who assessed that a referral to sexual health services was not required? ......................................................  **Date first seen by Sexual Health:** \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | |
| **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)?** \*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, 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](https://www.bashhguidelines.org/media/1196/syphillis-bp_print_2016_p3.pdf) | | | | | | |
| **PART 5: ADDITIONAL INFORMATION** | | | | | | |
| COVID-19 vaccine received  Yes  No  Not known  If 'Yes', please specify below which vaccine, number of doses and dates if known: ….………………………….… ……………………………………………………………………………………………………………………………….………… | | | | | | |
| Please enter any additional information in the space below: | | | | | | |