**CONFIDENTIAL**

HOSPITAL NAME: HOSPITAL CODE:

HOSP

**ISOSS syphilis antenatal screen positive notification**

***form date 07/20***

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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  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](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: …………………..  …………………………………………………………………………………………………………………………………………… | | | | | | | | | | | |
| **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](https://www.bashhguidelines.org/media/1196/syphillis-bp_print_2016_p3.pdf) | | | | | | | | | | | |
| **PART 6: ADDITIONAL INFORMATION** | | | | | | | | | | | |
| [Complete as necessary] | | | | | | | | | | | |

Form completed by: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please return using nhs.net secure email**