**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**[x]  **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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