Government of Saskatchewan

Notification Form - Infant exposed to syphilis in utero or during birth (pg 1)
Congenital syphilis (pgs 1 and 2)

Infant born with symptoms or **Child <2** confirmed with or presents with symptoms of congenital syphilis pgs 1&2

A) PERSON REPORTING – HEALTH CARE PROVIDER INFORMATION

Clinic Name: Location: Attending Physician or Nurse: Address: Phone number:	***FOR PUBLIC HEALTH OFFICE USE ONLY:*** **Service Area:** **Date Received:** **Panorama Client ID:** **Panorama Investigation ID:** **Panorama QA complete:** ☐ **Yes** ☐ **No** **Initials:**

B) INFANT INFORMATION

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MM / DD Age: _____ Health Card Province: _____ Health Card Number (PHN): **Outcome of Pregnancy** ☐ **Live Birth** ☐ **Stillbirth**	**Gender**: ☐ Male ☐ Female ☐ Unknown ☐ Other	If infant discharged to a guardian/caregiver other than birthing mother: Name: _____ Relationship: _____ Phone: ☐ Primary Home: ☐ Mobile contact: ☐ Home ☐ Work ☐ Text

Address Type: ☐No fixed ☐Postal Address ☐ Primary Home ☐Temporary ☐Legal Land Description
Mailing Address (Postal address):

Street Address or **First Nations Community** (Primary Home):

Infant's primary care provider/physician: Referral to Pediatric Infectious Disease physician: ☐ Yes ☐ No If yes, name of Infant's Pediatric ID physician:	LAB TEST INFORMATION (Check if ordered and enter date if collected): ☐ Serology Date specimen collected: YYYY/MM/DD ☐ Nasopharyngeal swab Date specimen collected: YYYY/MM/DD ☐ Lumbar puncture (CSF) Date specimen collected: YYYY/MM/DD ☐ Other_____ Date specimen collected: YYYY/MM/DD

C) MATERNAL INFORMATION (Biological)

Last Name:	First Name: Middle Name:	Alternate Name:
DOB: YYYY / MM / DD Age: _____	Health Card Province: _____ Health Card Number (PHN): _____	

D) RISK FACTORS (see page 2 for definitions)

Infant born to an infected mother Public Health also to enter in RF - Contact to known case	X Yes	☐ No	☐ Unknown	☐ Not asked
PRENATAL CARE INFORMATION (Public health to enter in Risk Factors)				
Maternal prenatal care **not received** *(select yes if no prenatal care)*	☐ Yes	☐ No	☐ Unknown	☐ Not asked
Maternal treatment for infection during pregnancy assessed as inadequate	☐ Yes	☐ No	☐ Unknown	☐ Not asked
Maternal treatment – inadequate serologic response documented during pregnancy	☐ Yes	☐ No	☐ Unknown	☐ Not asked
Maternal reinfection during pregnancy following successful treatment	☐ Yes	☐ No	☐ Unknown	☐ Not asked

Checklist of Additional Details:

Ophthamology Referral Completed ☐ Yes ☐ No
Audiology Referral Completed ☐ Yes ☐ No

Treatment Provided ☐ Yes ☐ No
if yes, complete G on page 2

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E) SIGNS & SYMPTOMS

Description	If yes, date of onset	Description	If yes, date of onset
Rhinitis/snuffles	YYYY / MM / DD	Hepatosplenomegaly	YYYY / MM / DD
Rash - palms	YYYY / MM / DD	Lab – anemia	YYYY / MM / DD
Rash - soles	YYYY / MM / DD	Lymphadenopathy	YYYY / MM / DD
Rash - trunk	YYYY / MM / DD	Meningitis	YYYY / MM / DD
Condyloma lata	YYYY / MM / DD	Osteochondritis (skeletal abnormalities)	YYYY / MM / DD
Hepatomegaly	YYYY / MM / DD	**Clinical signs of late congenital syphilis*** (> 2 years old on diagnosis)	YYYY / MM / DD

* May include Hutchinson's triad of interstitial keratitis, peg-shaped upper incisors, and eighth cranial nerve deafness

F) DISEASE EVENT HISTORY

Classification: ☐ Probable ☐ Confirmed

Staging: ☐ Early congenital (onset <2 years after birth) ☐ Late congenital (>2 years after birth)

G) TREATMENT (See SHA Treatment Order Sets)

Medical Order provided by: _____ **Treated By:** _____

☐ Penicillin G (specify dosage, route, frequency, duration) _____ **Date started:** YYYY / MM / DD

☐ Other (specify dosage, route, frequency, duration): _____ **Date started:** YYYY / MM / DD

H) IMMIGRATION INFORMATION

Country Born in: ☑ Canada ☐ Unknown ☐ _____

Country Emigrated from: _____ Arrival Date: YYYY / MMM / DD OR Arrival Year _____

I) OUTCOMES

☐ ICU/intensive medical care YYYY / MM / DD ☐ Hospitalization YYYY / MM / DD

☐ Other YYYY / MM / DD

☐ Fatal YYYY / MM / DD

Cause of Death: (if Fatal was selected) _____

Risk Factor Definitions

Maternal prenatal care not received	Perinatal transmission of communicable diseases is an increased risk among women who have not received prenatal care. This RF should be selected when women present for delivery and have not been seen during this pregnancy for pregnancy-related care.
Maternal treatment for infection during pregnancy assessed as inadequate	Perinatal transmission of communicable diseases is an increased risk among women who have not received adequate treatment. Treatment may require multiple doses of Bicillin (Penicillin G benzathine) with sufficient time before delivery. Enter this Risk Factor when treatment with Bicillin was not received during pregnancy or it was received but with insufficient time before delivery (the final dose was administered less than 30 days before delivery)
Maternal treatment - inadequate serologic response documented during pregnancy	Serologic monitoring is required to ensure treatment was adequate. Enter this Risk Factor when post-treatment serology was not done prior to delivery or serology indicated inadequate response
Maternal reinfection during pregnancy following successful treatment	This Risk Factor should be entered risk of perinatal transmission is due to reinfection following successful treatment. This may be an indicator of incomplete contact tracing.