Utah Department of **Health & Human** Services

IN PARTNERSHIP WITH UTAH'S **PUBLIC HEALTH** DEPARTMENTS

Confidential fax: ***(801) 538-9923*** *Email:* reporting@utah.gov

Congenital syphilis confidential case report form

Instructions

Complete all sections of this form using available data and fax or email the completed form to Utah public health. As syphilis is a reportable disease, client consent to release this information to Utah public health is* ***not required*** *and disease reporting is mandatory per Utah State Health Code 26B.*

**Case reports submitted via email need to be sent securely via an encryption service such as Virtru.*

Demographic information

Infant's last name: Infant's first name: MI:

Date of birth: ____/____/____ Birth sex: *(check one)* □ M □ F

Address: City: State: ZIP:

Infant's vital status: □ Alive □ Deceased (born alive then died) □ Stillborn

Birthweight (*in grams*): Gestational age (*in weeks*):

Race: *(Check all that apply)*
□ White □ Black or African American □ American Indian or Alaska Native □ Asian
□ Native Hawaiian or Pacific Islander □ Unknown □ Other, specify: ______________________

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown

Laboratory information

Attach a copy of the lab results

Treatment information

See CDC STI Treatment Guidelines for treatment and evaluation recommendations for highly probable, possible, and less likely congenital syphilis.

Drug name: Dosage:

Administration route: Treatment start date: ____/____/____ Treatment end date: ____/____/____

Maternal information

Mother's last name: Mother's first name: MI:

Mother's date of birth: ____/____/____ Mother's phone number: (_____) ______ - __________

Infant name: ____________________________

Did the mother have a prenatal visit during the pregnancy? ◻ Yes ◻ No
In which trimester did the mother have her first prenatal visit? ◻ First trimester ◻ Second trimester ◻ Third trimester
Date of mother's first prenatal visit: _____/_____/_____
Date of mother's last menstrual period before delivery: _____/_____/_____
What was the mother's HIV status during pregnancy? ◻ Positive ◻ Negative ◻ Unknown
Mother's total number of pregnancies (includes current and previous pregnancies):
Mother's total number of live births:

Clinical information

Clinician name: __________________________ Clinician phone: (_______) _______ - _____________
Did the infant/child have an RPR test? ◻ Yes, reactive, titer: _____ ◻ Yes, indeterminate ◻ Yes, nonreactive ◻ No ◻ Unknown
Did the infant/child have long bone x-rays? ◻ Yes, changes consistent with congenital syphilis ◻ Yes, no signs of congenital syphilis ◻ No
Did the infant/child, placenta, or cord have darkfield exam, DFA, or special stain? ◻ Yes, detected ◻ Yes, indeterminate ◻ Yes, not detected ◻ No ◻ Unknown
Did the infant/child have CSF WBC count (leukocytes in cerebral spinal fluid)? ◻ Yes, elevated ◻ Yes, indeterminate ◻ Yes, normal ◻ No ◻ Unknown
Did the infant/child have a CSF protein test? ◻ Yes, elevated ◻ Yes, indeterminate ◻ Yes, normal ◻ No ◻ Unknown
Did the infant/child have a CSF-VDRL? ◻ Yes, reactive, titer: _____ ◻ Yes, indeterminate ◻ Yes, nonreactive ◻ No ◻ Unknown
Did the infant present with any signs or symptoms of congenital syphilis? ◻ Asymptomatic/none ◻ Condyloma lata ◻ Snuffles ◻ Rash of secondary syphilis ◻ Hepatosplenomegaly ◻ Pseudoparalysis ◻ Edema ◻ Other: ____

Reporting

Reporter's name: _____________________________ Phone number: (_______) _______ - _____________
Reporter's agency: ____________________________ Date reported to public health: _____/_____/_____