* CASE ACCESSION NUMBER	INVESTIGATION ID	ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)

CONGENITAL SYPHILIS INVESTIGATION FORM

CASE FORM

*I. INFANT CASE IDENTIFICATION

subject > client details > client demographics

1. **LAST NAME**	2. **FIRST NAME**	3. **DATE OF BIRTH/DELIVERY** YYYY - MM - DD
4. **ALTERNATE LAST NAME**	5. **ALTERNATE FIRST NAME**	6. **SEX** O FEMALE O MALE O INTERSEX O UNKNOWN
7. **REGISTRATION NUMBER (FORMER MHSC)** 6 DIGITS	8. **HEALTH NUMBER (PHIN)** 9 DIGITS	9. **ALTERNATE ID** SPECIFY TYPE OF ID
10. **MOTHER'S ADDRESS AT TIME OF BIRTH ➔ ☐ ADDRESS IN FIRST NATION COMMUNITY**		11. **CITY/TOWN/VILLAGE**
12. **PROVINCE/TERRITORY**	13. **POSTAL CODE (OF ABOVE ADDRESS)** A#A #A#	14. **CURRENT PHONE NUMBER** ### - ### - ####

15. **RACIAL/ETHNIC IDENTITY (VOLUNTARY, PARENT/GUARDIAN SELF-REPORTED)**

☐ AFRICAN	☐ BLACK	☐ CHINESE	☐ DECLINED
☐ FILIPINO	☐ LATIN AMERICAN	☐ NORTH AMERICAN INDIGENOUS	☐ OTHER (SPECIFY):
☐ SOUTH ASIAN	☐ SOUTHEAST ASIAN	☐ WHITE	

16. **INDIGENOUS IDENTITY DECLARATION (VOLUNTARY, PARENT/GUARDIAN SELF-REPORTED)** O FIRST NATIONS O MÉTIS O INUIT O NOT ASKED O DECLINED	17. **FIRST NATIONS STATUS (VOLUNTARY, PARENT/GUARDIAN SELF-REPORTED)** O STATUS O NON-STATUS O NOT ASKED O DECLINED	**MHSU USE ONLY**
18. **ALTERNATE LOCATION INFORMATION (IF ANY)**		

II. TRANSMISSION EXPOSURE DETAILS
(DOCUMENT IN MATERNAL CASE INVESTIGATION)

investigation > exposure summary > create transmission event

MODE OF TRANSMISSION = PERINATAL;

19. **MOTHER'S LAST NAME**	20. **MOTHER'S FIRST NAME**	21. **MOTHER'S DATE OF BIRTH** YYYY - MM - DD
22. **MOTHER'S REGISTRATION NUMBER (FORMER MHSC)** 6 DIGITS	23. **MOTHER'S HEALTH NUMBER (PHIN)** 9 DIGITS	24. **ALTERNATE ID** SPECIFY TYPE OF ID
25. ☐ **MOTHER NOT IDENTIFIABLE**		

III.INVESTIGATION INFORMATION

investigation > investigation details > investigation information

26. ***INVESTIGATION DISPOSITION**	O FOLLOW-UP COMPLETE O UNABLE TO COMPLETE INTERVIEW O PENDING

investigation > investigation details > resp. org/investigator

27. ***RESPONSIBLE ORGANIZATION (PRIMARY)**	O WRHA O NRHA O PMH O SH-SS O IERHA O FNIHB O CSC
28. **OTHER RESPONSIBLE ORGANIZATIONS INVOLVED**	☐ WRHA ☐ NRHA ☐ PMH ☐ SH-SS ☐ IERHA ☐ FNIHB ☐ CSC ☐ DND

* IDENTIFIES CRITICAL DATA ELEMENT OR SECTION TO BE COMPLETED. IF THIS DATA IS MISSING, THE FORM WILL BE RETURNED.

MHSC– SURVEILLANCE UNIT: 4073H – 300 CARLTON ST. WINNIPEG, MB
CONFIDENTIAL FAX 204-948-3044

* CASE ACCESSION NUMBER	CASE NAME OR INITIALS	CASE PHIN

IV.*INFECTION INFORMATION

Refer to disease protocol: https://www.gov.mb.ca/health/publichealth/cdc/protocol/syphilis.pdf

investigation > investigation details > disease summary

29. STAGE	30. CASE CLASSIFICATION
☐ EARLY CONGENITAL (ONSET <2 YEARS AFTER BIRTH)	☐ LAB CONFIRMED ☐ PROBABLE ☐ NOT A CASE
☐ LATE CONGENITAL (>2 YEARS AFTER BIRTH)	☐ LAB CONFIRMED ☐ NOT A CASE
☐ SYPHILITIC STILLBIRTH	☐ LAB CONFIRMED ☐ PROBABLE ☐ NOT A CASE

31. **CASE CLASSIFICATION NOTES:** (SEE CASE DEFINITIONS ON PAGES 5 AND 6. IN PHIMS, DOCUMENT RATIONALE FOR CASE CLASSIFICATION AND CLINICIANS CONSULTED (E.G. PEDS ID) IN A NOTE).

V. SIGNS AND SYMPTOMS

investigation > signs and symptoms

32. **SIGNS AND SYMPTOMS** ○ ASYMPTOMATIC ○ SYMPTOMATIC ○ UNKNOWN

- ☐ CEREBROSPINAL FLUID (CSF) ABNORMALITIES (ELEVATED CSF CELL COUNT OR PROTEIN WITHOUT OTHER CAUSE)
- ☐ CHARACTERISTIC CLINICAL LATE MANIFESTATIONS OF SYPHILIS***
- ☐ CONDYLOMATA LATA
- ☐ HEPATOSPLENOMEGALY
- ☐ JAUNDICE
- ☐ PSEUDOPARALYSIS
- ☐ PCR POSITIVE
- ☐ RASH
- ☐ RADIOGRAPHIC EVIDENCE OF SYPHILIS IN LONG BONES
- ☐ REACTIVE CSF VDRL
- ☐ REACTIVE SEROLOGY
- ☐ REACTIVE SEROLOGY WITH RISING TITRES
- ☐ REACTIVE SEROLOGY WITH 4X HIGHER THAN MOTHER (ON SAME DATE)
- ☐ RUNNY NOSE (SNUFFLES)
- ☐ GESTATIONAL AGE AT BIRTH (SPECIFY IN WEEKS)
- ☐ BIRTHWEIGHT (SPECIFY IN GRAMS)
- ☐ OTHER (SPECIFY)

*** MAY INCLUDE KERATITIS, NERVE DEAFNESS, ANTERIOR BOWING OF SHINS, FRONTAL BOSSING, MULBERRY MOLARS, HUTCHINSON'S TEETH, SADDLE NOSE, RHAGADES, OR CLUTTON'S JOINTS.

VI. TREATMENT INFORMATION (FOR INFANT, EXCLUDES STILLBIRTHS)

investigation > prescriptions > prescription summary

33. PRESCRIBER NAME	34. TREATMENT FACILITY
SPECIFY	SPECIFY
☐ BENZATHINE PENICILLIN G (SPECIFY DOSAGE, ROUTE, FREQUENCY, DURATION, AND START DATE): SPECIFY START DATE: YYYY-MM-DD	☐ OTHER (SPECIFY DRUG, DOSAGE, ROUTE, FREQUENCY, DURATION, AND START DATE): SPECIFY START DATE: YYYY-MM-DD

35. **ALLERGIES (RELEVANT TO TREATMENT, IF ANY)**

subject > allergies

SPECIFY

VII. OUTCOMES AT TIME OF INVESTIGATION

investigation > outcomes

☐ HOSPITAL ADMISSION	☐ HOSPITAL DISCHARGE	☐ ICU ADMISSION	☐ ICU DISCHARGE
YYYY-MM-DD	YYYY-MM-DD	YYYY-MM-DD	YYYY-MM-DD
○ FATAL SPECIFY DATE OF DEATH YYYY-MM-DD		○ OTHER SIGNIFICANT OUTCOME/SEQUELAE SPECIFY	

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* CASE ACCESSION NUMBER	CASE NAME OR INITIALS	CASE PHIN

VIII. RISK FACTOR INFORMATION

subject > risk factors

COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED:	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
INFANT RISK FACTORS					
BORN TO INFECTED MOTHER	○	○	○	○	○
CONTACT TO A NEW OR PREVIOUSLY DIAGNOSED CASE (OTHER THAN MOTHER)	○	○	○	○	○
OTHER RISK FACTOR SPECIFY	○	○	○	○	○
MATERNAL RISK FACTORS					
HOUSING UNSTABLE	○	○	○	○	○
PRENATAL CARE RECEIVED (AT LEAST ONE VISIT FOR PREGNANCY-RELATED CARE) SPECIFY TRIMESTER OF FIRST VISIT	○	○	○	○	○
PRENATAL CARE – NUMBER OF VISITS (FOR ANY PREGNANCY-RELATED CARE) SPECIFY NUMBER OF VISITS	○	○	○	○	○
LABORATORY TESTING FOR SYPHILIS DURING FIRST TRIMESTER	○	○	○	○	○
LABORATORY TESTING FOR SYPHILIS AT 28-32 WEEKS GESTATION	○	○	○	○	○
LABORATORY TESTING FOR SYPHILIS AT DELIVERY	○	○	○	○	○
LABORATORY TESTING – NUMBER OF TIMES TESTED FOR SYPHILIS DURING PREGNANCY (INCLUDING DELIVERY) SPECIFY NUMBER OF TESTS	○	○	○	○	○
MATERNAL DIAGNOSIS DATE (DURING PREGNANCY) SPECIFY DATE YYYY-MM-DD	○	○	○	○	○
MATERNAL HISTORY OF STBBI'S (DURING PREGNANCY) SPECIFY INFECTIONS AND DATES DIAGNOSED	○	○	○	○	○
MATERNAL INCARCERATION DURING PREGNANCY	○	○	○	○	○
MATERNAL PARTNER WITH UNTREATED INFECTION	○	○	○	○	○
REINFECTION OR RELAPSE DURING PREGNANCY AFTER APPROPRIATE THERAPY (KNOWN OR SUSPECTED) SPECIFY DETAILS	○	○	○	○	○
SUBSTANCE USE DURING PREGNANCY (SELF DECLARED) SPECIFY SUBSTANCE(S) AND METHOD OF USE	○	○	○	○	○
SUBSTANCE USE DURING PREGNANCY – CRYSTAL METH (SELF DECLARED) SPECIFY METHOD OF USE	○	○	○	○	○
TREATMENT FOR INFECTION DURING PREGNANCY SPECIFY TREATMENT AND DATE ADMINISTERED YYYY-MM-DD	○	○	○	○	○
TREATMENT FOR INFECTION DURING PREGNANCY ASSESSED AS INADEQUATE (SEE CASE DEFINITIONS)	○	○	○	○	○
TREATMENT – INADEQUATE SEROLOGIC RESPONSE DOCUMENTED DURING PREGNANCY (SEE CASE DEFINITIONS)	○	○	○	○	○
OTHER RISK FACTOR SPECIFY	○	○	○	○	○

* CASE ACCESSION NUMBER	CASE NAME OR INITIALS	CASE PHIN

IX. EVIDENCE-BASED INTERVENTIONS

investigation > treatment and interventions >intervention summary

36. RECOMMENDED INTERVENTIONS	37. DATE (YYYY-MM-DD)
☐ REFERRAL FOR TREATMENT (SPECIFY)	
☐ REFERRAL TO PEDIATRIC INFECTIOUS DISEASES (SPECIFY DATE)	
☐ OTHER (SPECIFY)	

X.* REPORTER INFORMATION (IF NOT RESPONSIBLE REGIONAL PUBLIC HEALTH OFFICE)

38. FORM COMPLETED BY (PRINT NAME)	39. FACILITY NAME/ADDRESS		REPORTER USE ONLY
40. SIGNATURE	41. PHONE	42. FAX	
43. FORM COMPLETION DATE YYYY-MM-DD	44. ORGANIZATION (IF APPLICABLE) ○ WRHA ○ NRHA ○ PMH ○ SH-SS ○ IERHA ○ FNIHB ○ CSC		STAMP HERE

XI.* RESPONSIBLE REGIONAL PUBLIC HEALTH AUTHORITY USE ONLY (PRIMARY INVESTIGATOR)

investigation > investigation details > close investigation

45. FORM COMPLETED BY (PRINT NAME)	46. SIGNATURE	47. FORM COMPLETION DATE YYYY-MM-DD
48. FORM REVIEWED BY (PRINT NAME)	49. FORM REVIEWED DATE YYYY-MM-DD	RHA USE ONLY
50. INVESTIGATION STATUS ○ ONGOING ○ CLOSED TO THE REGION	51. ORGANIZATION ○ WRHA ○ NRHA ○ PMH ○ SH-SS ○ IERHA ○ FNIHB ○ CSC	STAMP HERE

**PLEASE SUBMIT THIS INVESTIGATION FORM BY SECURED FAX OR COURIER TO THE SURVEILLANCE UNIT AT MANITOBA HEALTH
AFTER HOURS EMERGENCY PHONE FOR PUBLIC HEALTH ISSUES: (204) 788-8666.**

THIS FORM IS ALSO AVAILABLE FOR DOWNLOAD IN A FILLABLE PDF FORMAT AT
http://www.gov.mb.ca/health/publichealth/surveillance/forms.html
A USER GUIDE FOR COMPLETION OF SURVEILLANCE FORMS FOR REPORTABLE DISEASES
AND INSTRUCTIONS FOR THIS FORM ARE AVAILABLE FOR DOWNLOAD AT
http://www.gov.mb.ca/health/publichealth/surveillance/forms.html

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