

Form Approved

OMB No. 0920-0128

Expiration Date: 00/00/0000

**Congenital Syphilis (CS) Case Investigation and Report Form**

**0920-0128**

**Attachment 3c**

Local Use Only

Mother's Name: \_\_\_\_\_

Chart No.: \_\_\_\_\_

Mother's Case ID No.: \_\_\_\_\_

Address: \_\_\_\_\_  
(Number, Street, City, State) (Zip Code)

(Zip Code)

Phone No.: ( ) \_\_\_\_\_

Infant's Name: \_\_\_\_\_

Chart No.: \_\_\_\_\_

Delivering Physician: \_\_\_\_\_

Phone No.: ( ) \_\_\_\_\_

Pediatrician n: \_\_\_\_\_

Phone No.: ( ) \_\_\_\_\_

Delivering Hospital: \_\_\_\_\_

- Patient identifier information is **not** transmitted to CDC -

### CONGENITAL SYPHILIS (CS) CASE INVESTIGATION AND REPORT

Form Approved OMB No. 0920-0128 Exp. Date: MM/YYYY

CASE ID No.: (1-7) \_\_\_\_\_

Local Use ID No.: \_\_\_\_\_

OB/Gyn: \_\_\_\_\_  
Other geographic unit: \_\_\_\_\_

DEPARTMENT OF HEALTH & HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL and PREVENTION  
ATLANTA, GA 30333

<b>1. Report</b> date to health dept. 9 <input type="checkbox"/> Unk  Mo. ___ / Day ___ / Yr. ___	<b>2. Reporting</b> state FIPS code: 9 <input type="checkbox"/> Unk  _____ Reporting State Name	<b>3. Reporting</b> county FIPS code: 9 <input type="checkbox"/> Unk  _____ Reporting County Name
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#### PART I. MATERNAL INFORMATION

<b>4. Mother's state</b> FIPS code: 9 <input type="checkbox"/> Unk  _____ Mother's Residence State	<b>5. Mother's Country</b> of residence: (leave blank if USA)  _____ Mother's Country of Residence		
<b>6. Mother's residence</b> county FIPS code: 9 <input type="checkbox"/> Unk  _____ Mother's Residence County	<b>7. Mother's residence</b> ZIP code: 9 <input type="checkbox"/> Unk  _____	<b>8. Mother's date of birth:</b> 9 <input type="checkbox"/> Unk  Mo. ___ / Day ___ / Yr. ___	<b>9. Mother's obstetric history:</b> G___ P___ _____ (G=pregnancies, P=live births)
<b>10. Last menstrual period (LMP)</b> (before delivery) 9 <input type="checkbox"/> Unk  Mo. ___ / Day ___ / Yr. ___	<b>11. a) Indicate</b> date of first prenatal visit: 0 <input type="checkbox"/> No prenatal care ( <b>Go to Q12</b> ) 9 <input type="checkbox"/> Unk  Mo. ___ / Day ___ / Yr. ___		
<b>12. Mother's ethnicity:</b> Latino 1 <input type="checkbox"/> Hispanic or 2 <input type="checkbox"/> Non-Hispanic or Latino 9 <input type="checkbox"/> Unk		<b>11. b) Indicate</b> trimester of first prenatal visit: 1 <input type="checkbox"/> 1st trimester 2 <input type="checkbox"/> 2nd trimester 3 <input type="checkbox"/> 3rd trimester	
<b>13. Mother's race:</b> (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American Pacific <input type="checkbox"/> Native Hawaiian or Other <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unk Islander			

<b>14. Did mother have non-treponemal or treponemal tests at:</b> <b>a) first prenatal visit?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk <b>b) 28-32 weeks gestation?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk <b>c) delivery?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk	<b>15. Mother's marital status:</b> 1 <input type="checkbox"/> Single, never married 3 <input type="checkbox"/> Separated/Divorced 8 <input type="checkbox"/> Other 2 <input type="checkbox"/> Married 4 <input type="checkbox"/> Widow 9 <input type="checkbox"/> Unk
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<b>16. Indicate</b> during pregnancy and delivery, dates and results of a) most recent and b) first <b>non-treponemal</b> tests:  Date Mo. Day Yr. Results Titer a. ___/___/___ 9 <input type="checkbox"/> Unk 1 <input type="checkbox"/> Reactive 2 <input type="checkbox"/> Nonreactive 9 <input type="checkbox"/> Unk 1: _____ b. ___/___/___ 9 <input type="checkbox"/> Unk 1 <input type="checkbox"/> Reactive 2 <input type="checkbox"/> Nonreactive 9 <input type="checkbox"/> Unk 1: _____	<b>19. What CLINICAL</b> stage of syphilis did mother have during pregnancy? 1 <input type="checkbox"/> primary 3 <input type="checkbox"/> early latent 5 <input type="checkbox"/> previously 9 <input type="checkbox"/> Unk treated/serofast 2 <input type="checkbox"/> secondary 4 <input type="checkbox"/> late or late latent 8 <input type="checkbox"/> Other
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<b>17. Indicate</b> during pregnancy, date, type, and result of a) first and b) most recent <b>treponemal</b> tests:  Date Mo. Day Yr. Test Type Results a. ___/___/___ 9 <input type="checkbox"/> Unk 1 <input type="checkbox"/> EIA or CLIA 3 <input type="checkbox"/> Other 1 <input type="checkbox"/> Reactiv e 2 <input type="checkbox"/> Nonreactiv e 9 <input type="checkbox"/> Unk 2 <input type="checkbox"/> TP-PA 9 <input type="checkbox"/> Unk b. ___/___/___ 9 <input type="checkbox"/> Unk 1 <input type="checkbox"/> EIA or CLIA 3 <input type="checkbox"/> Other 1 <input type="checkbox"/> Reactiv e 2 <input type="checkbox"/> Nonreactive 9 <input type="checkbox"/> Unk 2 <input type="checkbox"/> TP-PA 9 <input type="checkbox"/> Unk	<b>20. What SURVEILLANCE</b> stage of syphilis did mother have during pregnancy? (Footnote a) 1 <input type="checkbox"/> primary 3 <input type="checkbox"/> early latent 9 <input type="checkbox"/> Unk 2 <input type="checkbox"/> secondary 4 <input type="checkbox"/> late or late latent 8 <input type="checkbox"/> Other
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<b>18. What</b> was mother's HIV status during pregnancy? P <input type="checkbox"/> positive E <input type="checkbox"/> equivocal test X <input type="checkbox"/> patient not tested N <input type="checkbox"/> negative U <input type="checkbox"/> Unk	<b>21. When</b> did mother receive her first dose of benzathine penicillin?  ___/___/___ Mo. Day Yr. 1 <input type="checkbox"/> Before pregnancy 3 <input type="checkbox"/> 2nd trimester 5 <input type="checkbox"/> No Treatment ( <b>Go to Q24</b> ) 2 <input type="checkbox"/> 1st trimester 4 <input type="checkbox"/> 3rd trimester 9 <input type="checkbox"/> Unk
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<b>19. What</b> was mother's treatment? 1 <input type="checkbox"/> 2.4 M units benzathine penicillin 3 <input type="checkbox"/> 7.2M units benzathine penicillin 9 <input type="checkbox"/> Unk 2 <input type="checkbox"/> 4.8 M units benzathine penicillin 8 <input type="checkbox"/> Other
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#### PART II. INFANT/CHILD INFORMATION

<b>24. Date</b> of Delivery: 9 <input type="checkbox"/> Unk  Mo. ___ / Day ___ / Yr. ___	<b>25. Vital</b> status: 1 <input type="checkbox"/> Alive ( <b>Go to Q27</b> ) 3 <input type="checkbox"/> Stillborn ( <b>Go to Q27</b> ) (Footnote c) 2 <input type="checkbox"/> TP-PA 9 <input type="checkbox"/> Unk	<b>26. Indicate</b> date of death 9 <input type="checkbox"/> Unk  Mo. ___ / Day ___ / Yr. ___	<b>23. Did</b> mother have an appropriate serologic response? (Footnote b) 1 <input type="checkbox"/> Yes, appropriate response 3 <input type="checkbox"/> Response could not be determined from available non-treponemal titer information
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	2 <input type="checkbox"/> Born alive, then died	9 <input type="checkbox"/> Unknown (Go to Q27)		2 <input type="checkbox"/> No, inappropriate response: evidence of treatment failure or reinfection	4 <input type="checkbox"/> Not enough time for titer to change					
27. Birthweight (in grams) 9 <input type="checkbox"/> Unk	28. Estimated gestational age (in weeks) 99 <input type="checkbox"/> Unk <i>(If infant was stillborn go to Q37)</i>	29. a) Did infant/child have a reactive infant/child's first non-treponemal test for syphilis? (eg., VDRL, RPR) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> No test 9 <input type="checkbox"/> Unk Yr. (Go to Q30 unless reactive)	b) When was the infant/child's first reactive non-treponemal test for syphilis? ____/____/____ Mo. Day	c) Indicate titer of infant/child's non-treponemal test for syphilis 1: _____						
30. a) Did infant/child have a reactive treponemal test for syphilis (footnote d) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> No test 9 <input type="checkbox"/> Unk			b) When was the infant/child's first reactive treponemal test for syphilis? (footnote d) ____/____/____ Mo. Day Yr.							
31. Did the infant/child, placenta, or cord have darkfield exam, DFA, or special stains? 1 <input type="checkbox"/> Yes, positive 2 <input type="checkbox"/> Yes, negative			3 <input type="checkbox"/> No test 4 <input type="checkbox"/> No lesions and no tissue to test 9 <input type="checkbox"/> Unk							
32. Did the Infant/child have any signs of CS? (check all that apply)	<input type="checkbox"/> no signs/asymptomatic (Footnote e)	<input type="checkbox"/> condyloma Lata	<input type="checkbox"/> snuffles	<input type="checkbox"/> syphilitic skin rash	<input type="checkbox"/> hepato splenomegaly	<input type="checkbox"/> jaundice/hepatitis	<input type="checkbox"/> pseudo paralysis	<input type="checkbox"/> edema	<input type="checkbox"/> other	<input type="checkbox"/> Unk
33. Did the infant/child have long bone X-rays? 1 <input type="checkbox"/> Yes, changes consistent with CS			2 <input type="checkbox"/> Yes, no signs of CS			3 <input type="checkbox"/> No X-rays			9 <input type="checkbox"/> Unk.	
34. Did the infant/child have a CSF-VDRL? 1 <input type="checkbox"/> Yes, reactive			2 <input type="checkbox"/> Yes, nonreactive			3 <input type="checkbox"/> No test			9 <input type="checkbox"/> Unk.	
35. Did the infant/child have a CSF WBC count or CSF protein test? (Footnote f) 1 <input type="checkbox"/> Yes, CSF WBC count elevated			2 <input type="checkbox"/> Yes, CSF protein elevated			3 <input type="checkbox"/> both tests elevated			4 <input type="checkbox"/> neither test elevated 5 <input type="checkbox"/> No test 9 <input type="checkbox"/> Unk	
36. Was the infant/child treated? 1 <input type="checkbox"/> Yes, with Aqueous or Procaine Penicillin for 10 days ("2" is an obsolete response)			3 <input type="checkbox"/> Yes, with Benzathine penicillin x 1			4 <input type="checkbox"/> Yes, with other treatment			5 <input type="checkbox"/> No treatment 9 <input type="checkbox"/> Unk	
<b>PART III. Congenital Syphilis Case Classification</b>			<b>37. Classification</b>							
1 <input type="checkbox"/> Not a case			2 <input type="checkbox"/> Confirmed case (Laboratory confirmed identification of <i>T.pallidum</i> , e.g., darkfield exam, DFA, or special stains)			3 <input type="checkbox"/> Syphilitic stillbirth (Footnote c)			4 <input type="checkbox"/> Probable case (A case identified by the algorithm, which is not a confirmed case or syphilitic stillbirth).	

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0128). Do not send the completed form to this address.