**Ontario Congenital Syphilis Investigation Tool**

**Please complete the Birthing Parent Case iPHIS Entry Checklist on page 9 of this tool**

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| **Legend** | **♦ System-Mandatory ❖ Required** |

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| **Client Demographics (Infant case)** | |
| Client Last Name: | Client First Name: |
| Client Gender: | Client Date of Birth: YYYY-MM-DD |
| Client Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:**  **Specify \_ \_**  **Postal Code: Specify \_ \_** | Client Telephone #:  **Specify \_ \_**  Home  Mobile  Work  Other  Alternate Telephone #:  **Specify \_ \_**  Home  Mobile  Work  Other Email (if available):  **Specify \_ \_** |

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| **Client demographics (Maternal Case)** |  |
| iPHIS Client ID:  **Specify \_ \_** | iPHIS Encounter ID:  **Specify \_ \_** |
| Last Initial: | First Initial: |
| Gender: | Date of Birth: YYYY-MM-DD |
| Client Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:**  **Specify \_ \_**  **Postal Code: Specify \_ \_**  Same as infant address above | Client Telephone #:  **Specify \_ \_**  Home  Mobile  Work  Other  Alternate Telephone #:  **Specify \_ \_**  Home  Mobile  Work  Other Email (if available):  **Specify \_ \_** |

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| **Record of File** | | | | | |
| **♦ Responsible Health Unit** | **Date** | **♦ Investigator’s Name** | **Investigator’s Signature** | **Investigator’s Initials** | **Designation** |
| Specify | **❖**Investigation Start Date  YYYY-MM-DD | Specify | Specify | Specify | PHI  PHN  Other \_\_\_\_\_\_\_ |

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| **Call Log Details** | | | | | | | |
|  | **Date** | **Start Time** | **Type of Call** | **Call To/From** | | **Outcome**  **(contact made, v/m, text, email, no answer, etc.)** | **Investigator’s initials** |
| Call 1 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Call 2 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Call 3 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Call 4 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Date letter sent: YYYY-MM-DD | | | | | | | |

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| **Client Language / Proxy Information** | **Clinician/Health Care Provider Information** |
| Preferred Language:  English  French  Other:  **Specify \_ \_**  Translation required*?*  Yes  No Proxy respondent (if applicable)  Yes  No  Name:  **Enter name \_ \_**  Relationship to client  **Specify \_ \_** | Name: **Enter name \_ \_** Telephone #:  **Specify \_ \_**  Clinic/Hospital name:  **Specify \_ \_**  Role**:**  Attending Physician  Family Physician  Specialist  Walk-In Physician  Nurse Practitioner  Unknown  Other  **Enter role \_ \_** |

**Infant Case**

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| **CASE DETAILS** | | | |
| **Aetiologic Agent** | *Treponema Pallidum* | | |
| **Disease Code** | Early Congenital Syphilis  Late Congenital Syphilis  Syphilitic Stillbirth | | |
| **Encounter type** | Case | | |
| **♦ Classification** | Confirmed  Probable  Person Under Investigation (PUI)  Does Not Meet Definition | **♦ Classification Date** | YYYY-MM-DD |
| **♦ Encounter status** | Closed – Follow-up Complete  Closed – Duplicate-Do Not Use  Closed – Entered In Error  Closed – Lost to Follow Up  Closed – Does Not Meet Definition  Closed – Referred to MOHLTC  Closed – Referred to FNIHB  Open – Ongoing Monitoring  Open – Referred to other PHU | **♦ Date** | YYYY-MM-DD |

| **CLINICAL DETAILS** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| **SYMPTOMS** | | | | | | |
| **♦ Symptom** | **♦ Response** | | | | | **❖ Onset Date**  YYYY-MM-DD |
| **Yes** | **No** | **Don’t know** | **Not asked** | **Refused** |
| **Asymptomatic** |  |  |  |  |  | YYYY-MM-DD |
| **Anemia** |  |  |  |  |  | YYYY-MM-DD |
| **Ascites** |  |  |  |  |  |  |
| **Cardiovascular manifestations** |  |  |  |  |  | YYYY-MM-DD |
| Condylomata lata |  |  |  |  |  |  |
| **Congenital rhinitis (snuffles)** |  |  |  |  |  | YYYY-MM-DD |
| Deafness |  |  |  |  |  | YYYY-MM-DD |
| Enlarged liver and spleen (hepatosplenomegaly) |  |  |  |  |  | YYYY-MM-DD |
| Fever |  |  |  |  |  |  |
| Hair loss (alopecia) |  |  |  |  |  |  |
| Headache |  |  |  |  |  |  |
| Hutchinson teeth |  |  |  |  |  | YYYY-MM-DD |
| Interstitial keratitis |  |  |  |  |  | YYYY-MM-DD |
| Iritis |  |  |  |  |  |  |
| Jaundice |  |  |  |  |  | YYYY-MM-DD |
| Lesions, gummatous |  |  |  |  |  |  |
| Lymph nodes swelling/pain (lymphadenopathy) |  |  |  |  |  |  |
| Mucosal lesions |  |  |  |  |  | YYYY-MM-DD |
| Mucous patches |  |  |  |  |  |  |
| Mulberry molars |  |  |  |  |  | YYYY-MM-DD |
| Necrotizing funisitis |  |  |  |  |  | YYYY-MM-DD |
| Neurological symptoms |  |  |  |  |  |  |
| Osseous lesions |  |  |  |  |  |  |
| Osteochondritis |  |  |  |  |  | YYYY-MM-DD |
| Perichondritis |  |  |  |  |  | YYYY-MM-DD |
| Rash |  |  |  |  |  | YYYY-MM-DD |
| Rash, macular |  |  |  |  |  |  |
| Rash, maculopapular |  |  |  |  |  |  |
| Rash, papular |  |  |  |  |  |  |
| Retinitis |  |  |  |  |  |  |
| Saber shins |  |  |  |  |  | YYYY-MM-DD |
| Saddlenose |  |  |  |  |  | YYYY-MM-DD |
| Thrombocytopenia |  |  |  |  |  | YYYY-MM-DD |
| Uveitis |  |  |  |  |  |  |
| Other (specify): |  |  |  |  |  | YYYY-MM-DD |
| Other (specify): |  |  |  |  |  | YYYY-MM-DD |

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| **SEROLOGICAL TESTING** | | | |
| **❖ Reason for Testing:**  **□** Symptoms **□** Maternal exposure **□** Post-mortem **□** Other: ­­­\_\_\_\_\_\_\_\_\_\_\_ **□** Unknown | | | |
| **❖ Testing History (Serology):** | | | |
| **Specimen Collection Date** | **Chemiluminescent Microparticle Immunoassay (CMIA)** | **Rapid Plasma Reagin (RPR)  Enter titre if reactive** | **Treponema pallidum Particle Agglutination (TPPA)  if applicable** |
| YYYY-MM-DD | **□** Reactive **□** Non-reactive  **□** Inconclusive | **□** Reactive \_\_\_\_\_\_\_\_\_\_  **□** Non-reactive | **□** Reactive **□** Non-reactive  **□** Inconclusive |
| YYYY-MM-DD | **□** Reactive **□** Non-reactive  **□** Inconclusive | **□** Reactive \_\_\_\_\_\_\_\_\_\_  **□** Non-reactive | **□** Reactive **□** Non-reactive  **□** Inconclusive |
| YYYY-MM-DD | **□** Reactive **□** Non-reactive  **□** Inconclusive | **□** Reactive \_\_\_\_\_\_\_\_\_\_  **□** Non-reactive | **□** Reactive **□** Non-reactive  **□** Inconclusive |
| YYYY-MM-DD | **□** Reactive **□** Non-reactive  **□** Inconclusive | **□** Reactive \_\_\_\_\_\_\_\_\_\_  **□** Non-reactive | **□** Reactive **□** Non-reactive  **□** Inconclusive |

| **OTHER CLINICAL INVESTIGATIONS** | | | |
| --- | --- | --- | --- |
| **Test** | **Specimen Collection Date (leave blank if not done)** | **Specimen Site** | **Result** |
| **Direct fluorescence antibody (DFA)** | YYYY-MM-DD |  |  |
| **Nucleic acid amplification test (NAAT)** | YYYY-MM-DD |  |  |
| **Cerebrospinal fluid (CSF)** | YYYY-MM-DD |  | *Elevated CSF WBC:*  **□** Yes **□** No **□** Unknown  *Elevated CSF protein:*  **□** Yes **□** No **□** Unknown  *VDRL:*  **□** Reactive **□** Non-reactive **□** Inconclusive  *FTA ABS*  **□** Reactive **□** Non-reactive **□** Inconclusive |
| **Other:** | YYYY-MM-DD |  |  |
| **Radiography** | **Date Completed (leave blank if not done)** | **Site** | **Evidence of congenital syphilis** |
| **Long bone radiographs** | YYYY-MM-DD |  | **□** Yes **□** No  **□** Unknown |

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| **Treatment ❖** | Date(s) of treatment:  YYYY-MM-DD  YYYY-MM-DD  YYYY-MM-DD | Drug:  Dose:  Route:  IM  IV  Frequency:  Duration: |
| **Complications ❖** | None  Intrauterine growth restriction  Meningitis  Pseudoparalysis  Hydrops fetalis  Preterm birth (<37 weeks gestation)  Low birth weight  Small for gestational age  Unknown  Other  **Specify \_ \_** | |
| **Outcomes ❖** | Fatal  Unknown | |
|  | If fatal, Date of death: YYYY-MM-DD | |

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| **Infant Risk Factors** | | | | | |
| **Medical Risk Factors** | **❖ Response** | | | | **Details**  *iPHIS character limit: 50.* |
| **Yes** | **No** | **Unknown** | **Not asked** |
| Client was born to a case or carrier | ☐ | ☐ | ☐ | ☐ | If yes, specify |
| HIV status | ☐ | ☐ | ☐ | ☐ | ☐ Negative ☐ Positive ☐ Test not offered ☐ Test Refused  ☐ Unknown |
| Other | ☐ | ☐ | ☐ | ☐ |  |
| Unknown | ☐ | ☐ | ☐ | ☐ |  |

**Birthing Parent Case iPHIS Entry Checklist**

**In an effort to ensure comprehensive data is available to understand the epidemiology of congenital syphilis in Ontario, please revisit the birthing parent** **case/contact encounter associated with this congenital syphilis case and ensure the following items have been completed:**

Birthing parent case/contact linked to infant case

Birthing parent case/contact classification (staging) updated

Birthing parent treatment date and details are entered

Birthing parent case/contact risk factors completed (see Appendix A), specifically:

Pregnant

Prenatal care received

Received testing for syphilis >4 weeks prior to delivery

Received testing for syphilis during first trimester

Received testing for syphilis at 28-32 weeks gestation

Received testing for syphilis at delivery

Appropriate treatment for syphilis stage completed >4 weeks prior to delivery

**For assistance**

* Refer to **Appendix A** of this document for risk factor definitions
* Refer to PHO’s Syphilis (including Congenital Syphilis) iPHIS Quick Reference Guide
* Contact [Communicable.DiseaseControl@oahpp.ca](mailto:Communicable.DiseaseControl@oahpp.ca) for support, as needed

**Appendix A: Risk Factor Definitions**

**Birthing Parent Risk Factors**

**The following are to be completed for all pregnant cases of syphilis and all birthing parent cases associated with a congenital syphilis case (including non-infectious and infectious cases).**

**Prenatal Care Access**

* Prenatal care received (No, Yes: <4 visits, Yes: ≥4 visits, Unknown): Client received prenatal care. Select appropriate response from drop-down field.

**Screening Access**

* Received testing for syphilis >4 weeks prior to delivery (Yes, No, Unknown, Refused testing): Client was tested for syphilis >4 weeks prior to delivery of the fetus.
* Received testing for syphilis during first trimester (Yes, No, Unknown, Refused testing): Client received syphilis screening during their first trimester (prior to the end of the 12th week of pregnancy). This does not refer to follow-up testing for earlier syphilis infections or when a pregnant person is tested due to presentation of symptomatic infection.
* Received testing for syphilis at 28-32 weeks gestation (Yes, No, Unknown, Not applicable, Refused testing): Client received syphilis screening during the period between the start of the 28th week of pregnancy and the end of the 32nd week of pregnancy. This does not refer to follow-up testing for syphilis infections identified earlier in pregnancy or when a pregnant person is tested due to presentation of symptomatic infection.
* Received testing for syphilis at delivery (Yes, No, Unknown, Not applicable, Refused testing): Client received syphilis screening at the time of delivery. This does not refer to follow-up testing for syphilis infections identified earlier in pregnancy or when a pregnant person is tested due to presentation of symptomatic infection.

**Treatment Access**

* Appropriate treatment for syphilis stage completed >4 weeks prior to delivery *(*Yes, No, Unknown*):* Client completed an appropriate course of treatment for the stage of syphilis, as outlined in the [Canadian Guidelines for Sexually Transmitted Infections](https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/syphilis/treatment-follow-up.html#a2) > 4 weeks prior to delivery.