Massachusetts Department of Public Health

Bureau of Infectious Disease and Laboratory Sciences

Division of Surveillance, Analytics & Informatics

305 South Street, Jamaica Plain, MA 02130

*Phone: 617-983-6801 Confidential Fax:* 617-887-8789

To request **Partner Notification Services** for your patient, please call the Division of STD Prevention at **(617) 983-6940**

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| CONGENITAL SYPHILIS | **INFANT CASE REPORT FORM** |
| NEONATAL HERPES | Version 5/16/2018*For assistance filling out this form, call (617) 983-6801.* |
| OPHTHALMIA NEONATORUM | ***If you need help with this case, please call (617) 983-6940.*** |
| **INFANT INFORMATION**Last First DOB: / / Med Rec #: Name: Name: Middle Initial: Social Security #:  |
| Street Address: |  |  | Homeless | Gender: Male Female |
| Ethnicity: Hispanic/Latino Non-Hispanic Latino | Unknown |
| City: | Zip: |
| Race: (check all that apply) |
| White | Black | Asian | Native Hawaiian/Pacific Islander | American Indian/Alaskan Native Other  | Unknown |
| **MATERNAL INFORMATION**Last First DOB: / / Med Rec #: Name: Name: Middle Initial: Social Security #:  |
| Street Address:same as above Homeless Incarcerated | Cell Phone #: Home Phone #: Primary language spoken: Mother's country of origin: Length of time in the U.S.:  |
| **MATERNAL CLINICAL HISTORY**Gravida: Para:  | List STD tests performed on mother prior to delivery:Test: Result: Test: Result: Test: Result: Did mother receive treatment for any STD prior to delivery?Yes No Unknown If yes, list here:Test: Treatment date: / / Test: Treatment date: / / Test: Treatment date: / /  |
| Prenatal care received? Yes No Unknown |
| If yes, date of first prenatal visit: / / Total number of prenatal visits: Was mother tested for any STD prior to delivery? |
| Yes No Unknown |
| **BIRTH HISTORY**Birth setting: Home Hospital: Discharge date: / / Other, describe: Estimated Gestational Age: weeks days Birth weight: grams APGAR score: Ruptured membranes: hours prior to delivery. Artificially ruptured? Yes No UnknownMode of delivery: NSVD Elective caesarean Non-elective caesarean Assisted vaginal delivery: with forceps with vacuum |
| **INFANT CLINICAL INFORMATION**Prophylaxis received: Yes No Unknown | Did the patient have symptoms? Yes No UnknownIf symptomatic, what was the patient diagnosed with? (check all that apply) Skin infection CNS involvementEye infection Disseminated disease Mucous membrane infection SepsisLesions PneumoniaOther: Treatment Start Date: / / Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Treatment:  |
| If yes, name of medication:  |
| Date given: / /  |
| Diagnosis Date: / / Age at diagnosis: Months DaysWas patient hospitalized for this diagnosis? Yes No Unk |
| If yes, hospital address: Comorbidities:  \ |
| Outcome: Died Recovered Unknown |
| Date of death: / /  |
| **TESTING AGENCY INFORMATION**Provider Name: Facility: Phone #: Address: City: Zip: Fax:  |
| **TREATING CLINICIAN INFORMATION (If different from testing agency):** Same as testing agencyClinician Name: Facility: Phone #: Address: City: Zip: Fax:  |
| **ADMINISTRATIVE INFORMATION** Date Form Completed: / / Same as treating clinicianName/Contact Information of person completing report (if not treating clinician):   |