Massachusetts Department of Public Health
Bureau of Infectious Disease and Laboratory Sciences
Office of Integrated Surveillance and Informatics Services
305 South Street, Jamaica Plain, MA 02130
Phone: 617-983-6801 Confidential Fax: 617-983-6813

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

☐ CONGENITAL SYPHILIS
☐ NEONATAL HERPES
☐ OPHTHALMIA NEONATORUM

INFANT CASE REPORT FORM

Version 5/16/2018
For assistance filling out this form, call (617) 983-6801.
If you need help with this case, please call (617) 983-6940.

INFANT INFORMATION

Last Name:_______ First Name:_______ DOB:___/____/____ Middle Initial: _____ Med Rec #:_______ Social Security #:_______

Street Address: ☐ Homeless
City: Zip:

Gender: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic Latino ☐ Unknown

Race: (check all that apply)
☐ White ☐ Black ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other__________ ☐ Unknown

MATERNAL INFORMATION

Last Name:_______ First Name:_______ DOB:___/____/____ Middle Initial: _____ Med Rec #:_______ 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: ___________

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

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: _____/______/_______

BIRTH HISTORY

Birth settting: ☐ 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 ☐ Unknown

Mode of delivery: ☐ NSVD ☐ Elective caesarean ☐ Non-elective caesarean Assisted vaginal delivery: ☐ with forceps ☐ with vaccuum

INFANT CLINICAL INFORMATION

Prophylaxis received: ☐ Yes ☐ No ☐ Unknown

If yes, name of medication: ____________
Date given: _____/______/______
Diagnosis Date: _____/______/______
Age at diagnosis: ______Months ______Days
Was patient hospitalized for this diagnosis? ☐ Yes ☐ No ☐ Unk

If yes, hospital address: ____________
Comorbidities: ____________

Outcome: ☐ Died ☐ Recovered ☐ Unknown
Date of death: _______/_______/_______

Did the patient have symptoms? ☐ Yes ☐ No ☐ Unknown

If symptomatic, what was the patient diagnosed with? (check all that apply)
☐ Skin infection ☐ CNS involvement
☐ Eye infection ☐ Disseminated disease
☐ Mucous membrane infection ☐ Sepsis
☐ Lesions ☐ Pneumonia
☐ Other: ____________

Treatment Start Date: _____/______/________
Treatment:____________

TESTING AGENCY INFORMATION

Provider Name:____________ Facility:____________ Phone #:____________
Address:____________ City:____________ Zip:____________ Fax:____________

TREATING CLINICIAN INFORMATION (If different from testing agency):

☐ Same as testing agency
Clinician Name:____________ Facility:____________ Phone #:____________
Address:____________ City:____________ Zip:____________ Fax:____________

ADMINISTRATIVE INFORMATION

Date Form Completed: _____/______/______ ☐ Same as treating clinician
Name/Contact Information of person completing report (if not treating clinician):____________