Thunder Bay District Health Unit

Fax

To:
Company:
Fax:

From: **Sexual Health Clinic**
Phone: (807) 625-5976
Fax: (807) 625-4866
Date:
Pages:

MAIN OFFICE
999 Balmoral Street
Thunder Bay, Ontario
P7B 6E7

Toll free
in 807 area code
1-888-294-6630

Fax
Nurse Practitioner,
Sexual Health, Dental,
Septic, Library Service,
Speech and Audiology
(807) 623-2369

www.tbdhu.com

The Thunder Bay District Health Unit recently received a positive report of *syphilis* for a client in your care. Please complete and included form and fax the information to 625-4866 as soon as possible:

Please refer to the Canadian Paediatric Society's *Congenital Syphilis: No longer just of historical interest* (2018). If you require further assistance, please call a Public Health Nurse in the Sexual Health Program at 625-8347.

If you are no longer the provider for this patient, please indicate who this letter should be forwarded to.

Sincerely,

Sexual Health Program
Thunder Bay District Health Unit

Thunder Bay District Health Unit

Dear

Name of Infant:	**Name of Biological Mother:**
Gender:	**DOB:**
DOB:	**Address:**
Address:	**Phone:**
Phone:	**Is biological mother legal guardian? Yes/No**
	If No, who is legal guardian?

We have received a Syphilis laboratory report on the above mentioned infant. It is our responsibility to report all such cases confidentially to the Ministry of Health and Long Term Care. Please complete ALL information as indicated below in accordance with **the Health Protection and Promotion Act, Section 25 and 26**. Please complete the following questions and fax it to the Thunder Bay District Health Unit at (807) 625-4866 within **one week** of being received. Any questions regarding the collection of this information can be directed to the Manager of Sexual Health and Clinic Programs, 999 Balmoral St, Thunder Bay, ON P7B 6E7 807-625-5900 ext. 8841.

Diagnosis: Does the infant have syphilis?

☐ Yes *please specify*: ☐ Congenital (Early<2yrs or Late >2 yrs). Is infection control in place? Yes☐ No☐ ☐ Stage _____	☐ No *please specify: If congenital syphilis is not suspected, please indicate reason.* ☐ Maternal antibodies ☐ Other:_____

Reason for Testing:
☐ Routine Screening ☐ Postnatal Screening ☐ Contact Tracing ☐ Symptoms ☐ Post-mortem
☐Sexual Assault_____ if yes, did you report to child protection agency? Yes _____No_____
☐ Other: _____

Symptoms:

✓		✓	
☐	Asymptomatic	☐	Hutchinson teeth
☐	Skin lesions	☐	Early Fulminant disseminated infection
☐	Hydrops	☐	Mucocutaneous lesions
☐	Jaundice	☐	Osteochondritis
☐	Rhinitis	☐	Anemia
☐	Hepatosplenomegaly	☐	Neurosyphilis
☐	Interstitial keratitis	☐	Lymphadenopathy
☐	Bone involvement		

Lab results:

What is infants RPR and what is the source of the sample? _____
What is the infant's serial serology schedule? _____
Were any other syphilis investigations completed? _____

Has baseline and will monthly assessment for signs and symptoms of congenital syphilis for the first three months be completed? ☐ Yes ☐ No. Please specify_____

Treatment:
Is the infant receiving treatment? ☐ Yes ☐ No Infant weight:_____
Please specify medication, dose, route, frequency and duration_____
_____
_____

Contact Notification:

Has biological mother been informed of infant's test result? ☐ Yes ☐ No
Has the biological mother tested positive for syphilis? ☐ Yes ☐ No.
If yes, what was the date of test, RPR, staging and treatment received?

_____

Was the mother treated during pregnancy? ☐ Yes, at how many weeks? _____ ☐ No
Has repeat serology been completed for mother? Please specify what the current RPR is:

_____
Any concern about maternal re-infection post treatment? ☐ Yes ☐ No

Is the biological mother symptomatic? ☐ Yes ☐ No. If yes, what are the symptoms? _____
Were any lesions present at birth? ☐ Yes ☐ No
Is mother breastfeeding? ☐ Yes ☐ No
What was the delivery method of the infant? SVD_____, Caesarean_____, assisted vaginal delivery _____
Will you provide the biological mother with syphilis counselling? ☐ Yes ☐ No
Will you be following the baby? ☐ Yes ☐ No
If no, please provide name of physician: _____
Are there any other contacts of infant that need follow up? ☐ Yes ☐ No

If yes, please list any other contacts of the infant here (Name, DOB, Address, and Phone) and whether they have been notified and if follow up is complete. Please advise if you require Public Health assistance with contact tracing.

_____

_____

Syphilis Education

Has Syphilis education regarding testing and follow-up been provided to the infant's legal guardian? ☐ Yes ☐ No
Comments:_____
_____
_____

Do you require public health assistance? ☐ Yes ☐ No

As you are aware, Syphilis is a reportable infection under the HPPA, therefore the health unit will be receiving any positive serial serology results on this infant. If congenital syphilis has been ruled out, please notify the health unit in writing with accompanying diagnostic lab results.

Your cooperation in this matter is appreciated.

Sincerely,

Sexual Health Program
Thunder Bay District Health Unit

Signature of health care provider: _____ Date:_____