Massachusetts Department of Public Health
Bureau of Infectious Disease Prevention, Response & Services
Division of STD Prevention & HIV/AIDS Surveillance
305 South Street, Jamaica Plain, MA 02130
Phone: 617-983-6940 Confidential Fax: 617-983-6962

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 7/9/2013

For assistance filling out this form, call (617) 983-6940.

If you need help with this case, please call (617) 983-6940.

INFANT INFORMATION

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

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):_____