



Texas Department of State Health Services
 HIV/STD/TB/Viral Hepatitis Prevention and Care Branch
 STD-126 Syphilis Infant Reactor Control Record

| | | | | |
|----------------------------------|-----------------|--|---------------------------------------|----------------------------|
| Unique Identifier/Control Number | | Date Reported to Health Dept. (mm/dd/yyyy) | Date Morb Card Submitted (mm/dd/yyyy) | Date Assigned (mm/dd/yyyy) |
| - - | | | | |
| Surveillance Site | Reporting State | Reporting County | Reporting City | DIS Name |
| | 48 | | | |

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|---|---|---|--------------------------------------|---|
| Mother's Name: (Last, First, MI) | | Social Security Number | Date of Birth (mm/dd/yyyy) | Chart/Medical Record Number |
| Mother's Home Address and Phone Street Address: City: Phone: State: Zip Code: Alt: | | Race If other, describe: | | Prenatal Care Provider: Name: Address: Telephone No. |
| Did mother reside outside Texas during pregnancy? If yes, when: If yes, where: | | Ethnicity Hispanic/Latino Non-Hispanic/Latino Unknown | | Delivering Hospital/Physician Hospital: Physician: Address: Telephone No. |
| Last Menstrual Period (mm/dd/yyyy) | Mother's OB History (including this birth) G P A | Marital Status | | What was mother's clinical stage of syphilis during this pregnancy? |
| Unknown | | Substance use (UDS or Tox screen result) Alcohol Amphetamines Barbituates Benzodiazepines Cocaine Heroin Marijuana (THC) Methadone Morphine Oxycodone None Unk/not performed If other, list: | | |
| Indicate ALL trimesters the mother received care (check all that apply): None First Second Third Unk | | Indicate when mother had syphilis testing during the following: | | What was mother's surveillance stage of syphilis during her pregnancy? |
| First prenatal visit: (mm/dd/yyyy) | Number of prenatal visits: | First Prenatal* | 3rd Trimester (28-32 wks gestation)* | Other medical conditions |
| None Unknown | | Yes No Unk | Yes No Unk | |
| Mother's last known HIV Status: Positive Negative Equivocal Not Tested Unknown Date: | | Delivery | Yes No Unk | |
| Mother's insurance status during this pregnancy | | Date: | Date: | Date: |

MOTHER INFORMATION

| | | | | | | | | | |
|------------------------|---|--|---------|-----------|------|-------|----------|--------------|-------|
| Non-Treponemal History | Indicate during pregnancy and delivery, dates and results of tests: | | | | | | | | |
| | Date (mm/dd/yyyy) | | No test | Test Type | | | Results | | Titer |
| | Testing at Labor and Delivery | | | RPR | VDRL | Other | Reactive | Non-Reactive | 1: |
| | Third Trimester Test | | | RPR | VDRL | Other | Reactive | Non-Reactive | 1: |
| | First test during pregnancy | | | RPR | VDRL | Other | Reactive | Non-Reactive | 1: |

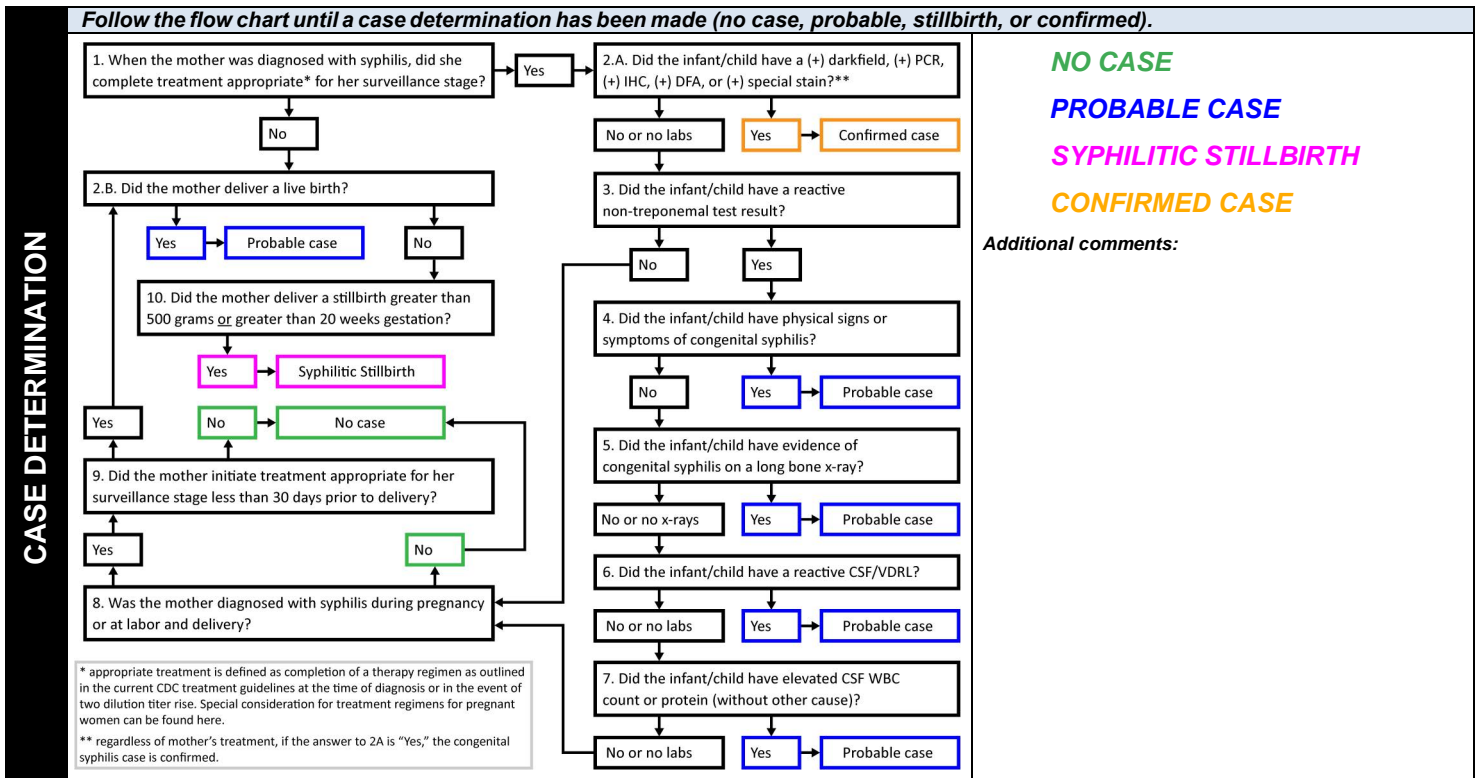
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|--------------------|---|--|-------------------|-------------------------------|-------------------------------|--|----------|--------------|--|
| Treponemal History | Indicate during pregnancy and delivery, dates and results of tests: | | | | | | | | |
| | Date (mm/dd/yyyy) | | No test performed | Test Type | | | Results | | |
| | Testing at Labor and Delivery | | | EIA or CIA TPPA FTA-ABS | Syphilis Healthcheck Other | | Reactive | Non-Reactive | |
| | Third Trimester Test | | | EIA or CIA TPPA FTA-ABS | Syphilis Healthcheck Other | | Reactive | Non-Reactive | |
| | First test during pregnancy | | | EIA or CIA TPPA FTA-ABS | Syphilis Healthcheck Other | | Reactive | Non-Reactive | |

| | | | |
|-------------------|----------------------------------|------|--|
| Treatment History | What was the mother's treatment? | Date | Following adequate treatment for mother's surveillance stage: |
| | | | Titer decreased Titer remained steady Titer fluctuated, but remained within one dilution Titer fluctuated, but more than one dilution increase without treatment or follow-up Titer fluctuated more than one dilution, but with follow-up returned within normal limits Titer showed evidence of treatment failure or reinfection Not enough time to evaluate titer change |



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Infant's Name: (Last, First) Date of Delivery (mm/dd/yyyy) Vital Status: Alive Stillborn
Infant Gender: Male Female Infant HIV Status: Date Did the infant have a non-treponemal test done?
Did the infant/child have any signs of congenital syphilis? (check all that apply)
Did the infant/child have long bone x-rays?
Did the infant/child have CSF-VDRL?
Did the infant/child have a CSF WBC count or CSF protein test?
Was the infant/child treated?



Supervisor's Approval Approved by: Date: