INFECTIOUS SYPHILIS NOTIFICATION FORM

This is a Schedule 1, Section C disease notifiable to the Medical Officer of Health under Sections 74 and 74AA of the Health Act 1956 using non-identifiable data.

Please complete the questionnaire below. Timely completion is a legal requirement.
Complete the first sections of the following questionnaire (health practitioner details, case details, demographics, basis of diagnosis, clinical and laboratory criteria) and assign a case classification.
If 'not a case', then there is no need to complete the rest of the form.

Health practitioner details

Name of health practitioner	
Name of organisation/clinic	
Email address	
Phone number	

Case details and Demographics

Sex (please note: this does not refer to gender identity)	☐ Male ☐ Female ☐ Unknown ☐ Indeterminate
Date of Birth	
NHI (National Health Index)	

Case Code

(Please complete the box with the first 2 letters of the surname (do not include the letters 'Mac', 'Mc', 'van der' if the surname starts with these), the first initial of given name, sex, and date of birth.)

1st letter surname	2nd letter surname	1st letter first name	Sex	Day		Month		Year	

For sexual health clinic cases, enter Clinic Patient ID	
City/town of residence at the time of diagnosis. For rural cases the nearest city/town	
District Health Board area where case resided at time of diagnosis	
Ethnicity (tick all that apply)	☐ NZ European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐ Niuean ☐ Chinese ☐ Indian ☐ Tongan ☐ Fijian (not Indian) ☐ Other (specify below) ☐ Unknown
Specify ethnicity	

Basis of diagnosis

Initial testing

Site of initial syphilis testing	☐ Public Sexual Health Clinic ☐ Family Planning Clinic ☐ General Practice ☐ Student Health Clinic ☐ Antenatal Clinic/Midwife ☐ NZ AIDS Foundation testing Clinic ☐ Body Positive testing Clinic ☐ Infectious Disease Clinic ☐ Obstetric Ward ☐ Paediatric Ward/Outpatients ☐ Emergency Department/A&E ☐ Corrections/Prison ☐ Other
If other, please specify	
Primary reason for syphilis testing	☐ Immigration purposes ☐ Syphilis contact ☐ Clinical symptoms or suspicion ☐ Contact of another STI/HIV ☐ Mother seropositive for syphilis ☐ Antenatal screening ☐ Asymptomatic screening including PrEP ☐ Other
If other, please specify	
Date patient presented	
If patient known to present to a 2nd clinical site for this episode (eg, sexual health clinic), enter 2nd date of presentation	

Clinical criteria

Has the case been symptomatic in the past 24 months?(tick all that apply)	☐ Genital ulceration ☐ Oral ulceration ☐ Anal ulceration ☐ Neurological symptoms ☐ Lymphadenopathy ☐ Rash ☐ Other ☐ No symptoms
If other, please specify	
Was the case pregnant at the time of diagnosis?	☐ Yes ☐ No ☐ Unknown
At what stage of pregnancy was this screening/testing done?	☐ First trimester ☐ Second trimester ☐ Third trimester ☐ Labour/Delivery

Laboratory criteria -Tick any tests that were done and the results

Non-Treponemal-specific serological tests	
☐ Rapid Plasma Reagin (RPR) test	Date of test
	Highest titre before treatment
	Seroconversion in past 2 years? ☐ Yes ☐ No ☐ Unknown
☐ Venereal Disease Research Laboratory (VDRL) test	Date of test
	Highest titre before treatment
	Seroconversion in past 2 years? ☐ Yes ☐ No ☐ Unknown
Treponemal-specific serological tests	
☐ Enzyme-linked IgG Immunosorbent Assay (EIA)	Date of test
	☐ Reactive ☐ Non-reactive
	Seroconversion in past 2 years? ☐ Yes ☐ No ☐ Unknown

☐ IgM immunoassay (IgM-EIA)	Date of test
	☐ Reactive ☐ Non-reactive
	Seroconversion in past 2 years? ☐ Yes ☐ No ☐ Unknown
☐ *Treponema pallidum* particle agglutination (TPPA)	Date of test
	☐ Reactive ☐ Non-reactive
	Seroconversion in past 2 years? ☐ Yes ☐ No ☐ Unknown
☐ *Treponema pallidum* hemagglutination assay (TPHA)	Date of test
	☐ Reactive ☐ Non-reactive
	Seroconversion in past 2 years? ☐ Yes ☐ No ☐ Unknown
Other tests	
☐ Detection of *Treponema pallidum* nucleic acid (NAAT)	Date of test
	Site of specimen
☐ Visualisation by direct fluorescent antibody (DFA)	Date of test
	Site of specimen
Previous tests for syphilis	☐ Yes ☐ No ☐ Unknown
If yes, date of last negative test (use 1/1/xxxx if only year is known)	
	☐ Date Approximate ☐ Date unknown

Case classification

Case classification- Please use data you have entered under clinical and laboratory criteria and the Ministry of Health Communicable Disease Control Manual case definition to decide on the case classification -If 'not a case', there is no need to complete the rest of the form

Case classification	☐ Under investigation ☐ Probable ☐ Confirmed ☐ Not a case

Clinical course and outcome

Date of onset	
	☐ Date Approximate ☐ Date unknown
Was the case hospitalised?	☐ Yes ☐ No ☐ Unknown
Date hospitalised	
	☐ Date unknown
Hospital	
Died	☐ Yes ☐ No ☐ Unknown
Date died	
	☐ Date Approximate ☐ Date unknown
Was this disease the primary cause of death?	☐ Yes ☐ No ☐ Unknown
If no, specify the primary cause of death	

Risk factors

Current gender identity (self-reported by patient):	☐ Male ☐ Female ☐ Transgender ☐ Other
If other, please specify gender identity	
Please specify	☐ Transgender male to female ☐ Transgender female to male ☐ Unknown

Born outside New Zealand	☐ Yes ☐ No ☐ Unknown
Specify country of birth	
HIV serostatus at the time of syphilis diagnosis	☐ Negative ☐ Positive ☐ Unknown
Was the case using HIV infection pre-exposure prophylaxis (PrEP)?	☐ Yes ☐ No ☐ Unknown
Date of HIV diagnosis (use 1/1/xxxx if only year is known)	
	☐ Date approximate ☐ Date unknown
Was the case on HIV antiretroviral treatment at the time of syphilis diagnosis?	☐ Yes ☐ No ☐ Unknown
Other concurrent diagnoses at time of syphilis diagnosis (tick all that apply)	☐ Chlamydia ☐ Gonorrhoea ☐ Trichomoniasis ☐ Genital herpes ☐ Genital warts ☐ Mycoplasma genitalium ☐ Lymphogranuloma venereum (LGV) ☐ Non-specific urethritis (NSU) ☐ Other
If other, please specify	
Sexual behaviour in the previous 12 months	☐ Opposite sex partners only ☐ Same sex partner only ☐ Both opposite and same sex partners ☐ Unknown ☐ Not applicable
Number of male sex partners in the past 3 months	
	☐ Exact ☐ Approximate
Number of male sex partners in the past 6 months	
	☐ Exact ☐ Approximate
Number of male sex partners in the past 12 months	
	☐ Exact ☐ Approximate
Number of female sex partners in the past 3 months	
	☐ Exact ☐ Approximate
Number of female sex partners in the past 6 months	
	☐ Exact ☐ Approximate
Number of female sex partners in the past 12 months	
	☐ Exact ☐ Approximate
Is the case a sex worker? (includes receiving money or drugs in exchange for sexual services)	☐ Yes ☐ No ☐ Unknown
From whom was this infection probably acquired?	☐ Casual partner(s) ☐ Regular partner(s) ☐ Client(s) (if sex worker) ☐ Sex worker(s) ☐ Unknown
If sex worker(s) ticked above, what is the gender identity of the worker	☐ Male ☐ Female ☐ Transgender ☐ Other ☐ Unknown
The sexual partner(s) above was/were	☐ Person(s) of the opposite sex only ☐ Person(s) of the same sex only ☐ Person(s) of both sexes ☐ Unknown sexual exposure

Source of Infection

Where was the infection most likely acquired?	☐ New Zealand ☐ Overseas ☐ Unknown
City/town where the infection most likely acquired	☐ Auckland ☐ Christchurch ☐ Dunedin ☐ Hamilton ☐ Wellington ☐ Other
Please specify city/town name or for rural cases the nearest city/town	
If overseas, please specify country	

Management

Current infection treated as per the New Zealand Sexual Health Society Syphilis Guideline	☐ Yes ☐ No ☐ Unknown
Contact management: Contact tracing of partners is the responsibility of the treating doctor and an essential component of the clinical and public health management of cases. For guidance please see the New Zealand Sexual Health Society Contact Tracing Guideline ☐ I have already initiated, or plan to undertake, contact tracing ☐ I have already referred this case to another service for contact tracing as per local protocols/processes ☐ Contact tracing incomplete due to anonymous contacts (e.g. sex onsite venue, internet based App, internet dating)	
Comments	

Please return by mail or fax to STI Analyst:
Health Intelligence Team - ESR, PO Box 50-348, Porirua 5240
Fax: 04 978 6690

For any questions about completion of the form, please contact your local public health unit or KSC.STISyph@esr.cri.nz