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- Please use data you have entered under clinical and laboratory criteria and the Ministry of Health [Communicable Disease Control Manual case definition](https://www.health.govt.nz/our-work/diseases-and-conditions/communicable-disease-control-manual/syphilis-case-definition-only) 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](http://www.nzshs.org/docman/guidelines/management-of-sexual-health-conditions/syphilis/174-syphilis-guideline/file) | 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](http://www.nzshs.org/docman/guidelines/principles-of-sexual-health-care/144-partner-notification-guideline/file)  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](mailto:KSC.STISyph@esr.cri.nz)