

CONGENITAL 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)	<input type="checkbox"/> Male	<input type="checkbox"/> Female
	<input type="checkbox"/> Unknown	<input type="checkbox"/> 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. For new-born or still birth, if names unknown, use "Baby" as first name and mother's surname)

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

Mother's 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.)

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

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)

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> NZ European | <input type="checkbox"/> Māori |
| <input type="checkbox"/> Samoan | <input type="checkbox"/> Cook Island Māori |
| <input type="checkbox"/> Niuean | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Indian | <input type="checkbox"/> Tongan |
| <input type="checkbox"/> Other | <input type="checkbox"/> Unknown |

If other, please specify ethnicity

Basis of diagnosis

Initial testing

Site of initial syphilis testing	<input type="checkbox"/> Public Sexual Health Clinic <input type="checkbox"/> Family Planning Clinic <input type="checkbox"/> General Practice <input type="checkbox"/> Student Health Clinic <input type="checkbox"/> Antenatal Clinic <input type="checkbox"/> NZ AIDS Foundation testing Clinic <input type="checkbox"/> Body Positive testing Clinic <input type="checkbox"/> Infectious Disease Clinic <input type="checkbox"/> Obstetric Ward <input type="checkbox"/> Paediatric Ward/Outpatients <input type="checkbox"/> Other
If other, please specify	
Primary reason for syphilis testing	<input type="checkbox"/> Immigration purposes <input type="checkbox"/> Syphilis contact <input type="checkbox"/> Clinical symptoms or suspicion <input type="checkbox"/> Mother seropositive for syphilis <input type="checkbox"/> Antenatal screening <input type="checkbox"/> Asymptomatic screening <input type="checkbox"/> Other
If other, please specify	
Date patient presented	

Clinical criteria

Indicate fetus/infant/child details (tick all that apply)	<input type="checkbox"/> Still birth <input type="checkbox"/> Bone deformities on radiographs of long bones <input type="checkbox"/> Elevated CSF white blood cell count or protein <input type="checkbox"/> Other
If other, please specify	
Gestation at delivery (weeks in integer)	
Did the mother test seropositive using a treponemal-specific test (TPPA, TPHA, IgG EIA, IgM) during the perinatal period?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, was mother treated adequately as per the New Zealand Sexual Health Society Syphilis Guideline	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Did the mother test seropositive using a non-treponemal-specific test (RPR, VDRL) during the perinatal period?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, was mother treated adequately as per the New Zealand Sexual Health Society Syphilis Guideline	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Laboratory criteria - Tick any tests that were done and the results (for the case)

Non-Treponemal-specific serological tests	
<input type="checkbox"/> Rapid Plasma Reagin (RPR) test	Date of test
	Highest titre before treatment
<input type="checkbox"/> Venereal Disease Research Laboratory (VDRL) test	Date of test
	Highest titre before treatment
Treponemal-specific serological tests	
<input type="checkbox"/> Enzyme-linked IgG Immunosorbent Assay (EIA)	Date of test
	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive
<input type="checkbox"/> IgM immunoassay (IgM-EIA)	Date of test
	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive
<input type="checkbox"/> <i>Treponema pallidum</i> particle agglutination (TPPA)	Date of test
	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive

<input type="checkbox"/> <i>Treponema pallidum</i> hemagglutination assay (TPHA)	Date of test
	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive
Other tests	
<input type="checkbox"/> Detection of <i>Treponema pallidum</i> nucleic acid (NAAT)	Date of test
	Site of specimen
<input type="checkbox"/> Visualisation by direct fluorescent antibody (DFA)	Date of test
	Site of specimen
Are infant serum non-treponemal (RPR or VDRL) titres > four-fold higher than maternal serum titres?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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](#) to decide on the case classification

Case classification	<input type="checkbox"/> Under investigation	<input type="checkbox"/> Probable
	<input type="checkbox"/> Confirmed	<input type="checkbox"/> Not a case

Clinical course and outcome- If still birth, do not complete

Was the case hospitalised?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Date hospitalised	
	<input type="checkbox"/> Date unknown
Hospital	
Died	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Date died	
	<input type="checkbox"/> Date Approximate <input type="checkbox"/> Date unknown
Was this disease the primary cause of death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If no, specify the primary cause of death	

Risk factors

Born outside New Zealand	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Specify country of birth	
Other concurrent diagnoses at time of syphilis diagnosis (tick all that apply)	<input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhoea
	<input type="checkbox"/> Trichomoniasis <input type="checkbox"/> Genital herpes
	<input type="checkbox"/> Genital warts <input type="checkbox"/> Mycoplasma genitalium
	<input type="checkbox"/> Lymphogranuloma venereum (LGV) <input type="checkbox"/> Other
If other, please specify	
Was the mother screened/tested for syphilis during her pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Was this at her first antenatal visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
At what stage of pregnancy was this screening/testing done?	<input type="checkbox"/> First trimester <input type="checkbox"/> Second trimester
	<input type="checkbox"/> Third trimester <input type="checkbox"/> Labour/Delivery
What stage of syphilis did the mother have during the pregnancy?	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
	<input type="checkbox"/> Early latent <input type="checkbox"/> Late latent
	<input type="checkbox"/> Previously treated <input type="checkbox"/> Unknown <input type="checkbox"/> Other
If other, please specify	

Management

Current infection treated as per the New Zealand Sexual Health Society Syphilis Guideline	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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