

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)	<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.)															
<table border="1"> <thead> <tr> <th>1st letter surname</th> <th>2nd letter surname</th> <th>1st letter first name</th> <th>Sex</th> <th>Day</th> <th>Month</th> <th>Year</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		1 st letter surname	2 nd letter surname	1 st letter first name	Sex	Day	Month	Year							
1 st letter surname	2 nd letter surname	1 st 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)	<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 (specify below) <input type="checkbox"/> Unknown														
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

Has the case been symptomatic in the past 24 months?(tick all that apply)	<input type="checkbox"/> Genital ulceration <input type="checkbox"/> Oral ulceration <input type="checkbox"/> Neurological symptoms <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Rash <input type="checkbox"/> Other <input type="checkbox"/> No symptoms
If other, please specify	
Was the case pregnant at the time of diagnosis?	<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

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

Non-Treponemal-specific serological tests	
<input type="checkbox"/> Rapid Plasma Reagin (RPR) test	Date of test
	Highest titre before treatment
	Seroconversion in past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/> Venereal Disease Research Laboratory (VDRL) test	Date of test
	Highest titre before treatment
	Seroconversion in past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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
	Seroconversion in past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/> IgM immunoassay (IgM-EIA)	Date of test
	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive
	Seroconversion in past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/> <i>Treponema pallidum</i> particle agglutination (TPPA)	Date of test
	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive
	Seroconversion in past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

<input type="checkbox"/> <i>Treponema pallidum</i> hemagglutination assay (TPHA)	Date of test
	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive
	Seroconversion in past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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
Previous tests for syphilis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, date of last negative test (use 1/1/xxxx if only year is known)	
	<input type="checkbox"/> Date Approximate <input type="checkbox"/> 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](#) to decide on the case classification -If 'not a case', there is no need to complete the rest of the form

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

Date of onset	
	<input type="checkbox"/> Date Approximate <input type="checkbox"/> Date unknown
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

Current gender identity (self-reported by patient):	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other
If other, please specify gender identity	
Please specify	<input type="checkbox"/> Transgender male to female <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender female to male
Born outside New Zealand	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Specify country of birth	
HIV serostatus at the time of syphilis diagnosis	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Unknown
Was the case using HIV infection pre-exposure prophylaxis (PrEP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Date of HIV diagnosis (use 1/1/xxxx if only year is known)	<input type="checkbox"/> Date approximate <input type="checkbox"/> Date unknown
Was the case on HIV antiretroviral treatment at the time of syphilis diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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	
Sexual behaviour in the previous 12 months	<input type="checkbox"/> Opposite sex partners only <input type="checkbox"/> Same sex partner only <input type="checkbox"/> Both opposite and same sex partners <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable
Number of male sex partners in the past 3 months	<input type="checkbox"/> Exact <input type="checkbox"/> Approximate
Number of male sex partners in the past 6 months	<input type="checkbox"/> Exact <input type="checkbox"/> Approximate
Number of male sex partners in the past 12 months	<input type="checkbox"/> Exact <input type="checkbox"/> Approximate
Number of female sex partners in the past 3 months	<input type="checkbox"/> Exact <input type="checkbox"/> Approximate
Number of female sex partners in the past 6 months	<input type="checkbox"/> Exact <input type="checkbox"/> Approximate
Number of female sex partners in the past 12 months	<input type="checkbox"/> Exact <input type="checkbox"/> Approximate
Is the case a sex worker? (includes receiving money or drugs in exchange for sexual services)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
From whom was this infection probably acquired?	<input type="checkbox"/> Casual partner(s) <input type="checkbox"/> Regular partner(s) <input type="checkbox"/> Client(s) (if sex worker) <input type="checkbox"/> Sex worker(s) <input type="checkbox"/> Unknown
If sex worker(s) ticked above, what is the gender identity of the worker	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Other <input type="checkbox"/> Unknown
The sexual partner(s) above was/were	<input type="checkbox"/> Person(s) of the opposite sex only <input type="checkbox"/> Person(s) of the same sex only <input type="checkbox"/> Person(s) of both sexes <input type="checkbox"/> Unknown sexual exposure
Where was the infection most likely acquired?	<input type="checkbox"/> New Zealand <input type="checkbox"/> Overseas <input type="checkbox"/> Unknown
City/town where the infection most likely acquired	<input type="checkbox"/> Auckland <input type="checkbox"/> Christchurch <input type="checkbox"/> Dunedin <input type="checkbox"/> Hamilton <input type="checkbox"/> Wellington <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<p>Contact management:</p> <p>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</p> <p><input type="checkbox"/> I have already initiated, or plan to undertake, contact tracing</p> <p><input type="checkbox"/> I have already referred this case to another service for contact tracing as per local protocols/processes</p> <p><input type="checkbox"/> Contact tracing incomplete due to anonymous contacts (e.g. sex onsite venue, internet based App, internet dating)</p>	
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