



Syphilis Case Report Form

Completed by: Date Completed:/...../.....

Position: Contact telephone:

CASE DETAILS: UR No: Person Id:

Name:
First name Surname Alias(es)

Date of birth:/...../..... Sex: Male Female Other

Female patients: Pregnant Not pregnant Unknown

Country of Birth: Australia Other - *specify*

Aboriginal Torres Strait Islander Both Aboriginal and Torres Strait Islander Non-Indigenous Unknown

Permanent address: Postcode:

Mobile Telephone:

Current Sex Worker (sex work in last 12 months) Yes No Unknown

REASON FOR SYPHILIS SCREENING: (Please tick all that apply)

- Contact of Syphilis
- Asymptomatic STI screening
- Symptomatic – *specify* Date of onset:/...../.....
- Contact of another STI – *specify*
- Antenatal Screening, gestation:/40
- HIV Pre-exposure prophylaxis (PrEP) screen Initial screen Ongoing screen
- Other – *specify*

SEXUAL CONTACTS/RISK INFORMATION:

Opposite sex Same sex Both sexes No sexual contact Unknown

Where was the infection most probably acquired?

- Queensland Interstate – *specify*
- Overseas – *specify* Unknown

Type of sex partner from whom the infection was most probably acquired?

- Regular Known casual Unknown casual Vertical transmission
- Other – *specify* Unknown

Where did the patient meet the sex partner from whom the infection was most probably acquired?

- Brothel Beat Internet Mobile app Sex on premises venue
- In community N/A regular partner Unknown
- Other – *specify*

Pathology		Results	
		Date:/...../.....	Date:/...../.....
RPR			
Treponemal Antibody (EIA/CMIA)			
TPPA/TPHA			
FTA-Abs			
PCR	Site 1	Date:/...../.....	Result:
Other – <i>specify</i>			

Case name:
First name Surname DOB/...../..... Person ID:

HISTORY:

Was the patient taking HIV pre-exposure prophylaxis (PrEP) at the time of diagnosis? Yes No Unknown
 Date of last PrEP dose:/...../.....

Has the patient been **tested** for syphilis previously? Yes No Unknown

If yes, provide details/results:

When was the last negative antibody test? Date:/...../..... Lab details (if known):

Has the patient been **treated** for syphilis previously? Yes (provide details of treatment below) No Unknown

SYPHILIS TREATMENT DETAILS: Record all available details of **current and past** treatment.
Keep this form until all planned treatment is complete and record exact dates of treatment

Date Given	Drug Details	Dose	Route	Comments

OTHER RELEVANT INFORMATION:

.....

CONTACT TRACING/PARTNER MANAGEMENT:

There is a sustained increase in **infectious syphilis** cases in **men who have sex with men** and **young Indigenous people**. Management of sexual partners is an important part of syphilis control.

Has partner notification (contact tracing) been initiated?

- 1. Yes, patient will notify partner/s
- 2. Yes, clinician will notify partner/s Name of doctor/clinician:
- 3. No – *specify*

If you require assistance with partner notification of infectious syphilis cases,
 please phone the Queensland Syphilis Surveillance Service on **1800 032 238**.

Clinical Guidelines for the management of syphilis and other sexually transmissible infections are available at the website: <http://www.health.qld.gov.au/clinical-practice/guidelines-procedures/sex-health/guidelines/default.asp>

Thank you for completing this form.

Please return to the Queensland Syphilis Surveillance Service

Post: Locked Bag 2, Stafford DC QLD 4053

Email: QLD-Syphilis-Surveillance-Service@health.qld.gov.au

Secure Fax: (07) 36241188

OFFICE USE ONLY:	Date QSSS notified:/...../.....	Notification ID:
Symptoms at first presentation: <input type="checkbox"/> Yes – <i>specify</i> <input type="checkbox"/> No symptoms		
<input type="checkbox"/> Public Hospital	<input type="checkbox"/> Private Hospital	<input type="checkbox"/> Sexual Health Clinic <input type="checkbox"/> Family Planning Clinic
<input type="checkbox"/> General Practice	<input type="checkbox"/> Point-Of-Care Test	<input type="checkbox"/> Aboriginal Medical Service <input type="checkbox"/> Prison/Detention Centre
<input type="checkbox"/> Primary Health Care Centre	<input type="checkbox"/> Other – <i>specify</i>	<input type="checkbox"/> Unknown