Syphilis Case Report Form

This is an approved form for the use and purpose of the ***Queensland Public Health Act 2005*** (Chapter 3 Part 2, Division 2 - Notices about notifiable conditions) and the ***Public Health Regulation 2018*** (Schedules 1 and 2)

Notifying clinician

Name:

Practice/facility: Telephone:

Patient details

URN: Client ID:

First name: Last name:

Address: Telephone:

Date of birth: Sex at birth: ☐ Male ☐ Female ☐ Unknown ☐ Other:

First Nations status: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Neither Aboriginal nor Torres Strait Islander ☐ Unknown

Country of birth: ☐ Australia ☐ Other (specify):

Main language other than English spoken at home:

Is the patient **pregnant**? ☐ Yes ☐ No ☐ Unknown Gestation at diagnosis: ____/40 Estimated birthing date:

Antenatal health care provider details:

Planned birthing hospital:

Reason for syphilis testing *(check all that apply)*

☐ Contact of a syphilis case

☐ Symptomatic syphilis Date of onset:

☐ Symptomatic STI

☐ Asymptomatic STI screening

☐ Contact of another STI case (specify):

☐ Confirm reactive point-of-care test

☐ Antenatal screening

☐ HIV PrEP - ☐ Initial ☐ Ongoing

☐ Corrections

☐ Drug and alcohol screening

☐ Mental health intake screening

☐ Cognitive/dementia screen

☐ Other reason for testing:

Symptoms *(check all that apply)*

☐ Chancre Location:

☐ Condylomata lata - raised flat topped grey/white lesions

☐ Rash (specify):

☐ Mucosal patches

☐ Lymphadenopathy

☐ Flu like symptoms

☐ Patchy alopecia

☐ Uveitis

☐ Fever

☐ Other (specify):

Previous syphilis testing and treatment

Has the patient been tested for syphilis interstate or overseas? ☐ Yes ☐ No ☐ Unknown

Has the patient been treated for syphilis interstate or overseas? ☐ Yes ☐ No ☐ Unknown

If yes, please provide details of where, when and what previous test or treatment was provided:

HIV PrEP and doxy-PEP

Was the patient taking HIV PrEP at time of diagnosis? ☐ Yes ☐ No ☐ Unknown

Was the patient taking doxy-PEP at time of diagnosis? ☐ Yes ☐ No ☐ Unknown

Syphilis treatment details

Keep this form until all planned treatment is complete and record exact dates of treatment.
Refer to Australian STI Management Guidelines for guidance. ***DO NOT*** *confuse benzathine benzylpenicillin with benzylpenicillin.*

Date given	Drug details	Dose	Route	Duration (if relevant)

Other relevant information:

Has the patient been referred to another service for management? ☐ Yes (specify): ☐ No

Sexual contact/risk information

Sexual exposure in the last 12 months: ☐ Opposite sex ☐ Same sex ☐ Both sexes ☐ No sexual contact ☐ Unknown

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

Where was the infection most probably acquired?

☐ Queensland (specify town/postcode if known): ☐ Interstate (specify):

☐ Overseas (specify): ☐ Unknown

Type of partner from whom the infection was most probably acquired:

☐Regular ☐Known casual ☐Unknown casual ☐Unknown ☐Vertical transmission ☐Other (specify):

For the contact tracing period, total number of: Identifiable contacts: Non-identifiable contacts:

Contact tracing/partner management

Sexual partners should be notified by the diagnosing clinician or the patient.

Has partner notification (contact tracing) been initiated?

☐ Yes ☐ No (specify):

☐ Unknown ☐ Not required (specify):

Are there any partners who are, or may be pregnant? ☐ Yes *(urgent follow up is required)* ☐ No ☐ Unknown

Social vulnerabilities *(check all that apply)*

Please complete this section if appropriate, noting there are sensitivities when requesting this information. Social vulnerabilities may impact a person's transmission risk, or their ability to adhere to the clinical follow up for adequate treatment.

Does your client identify as having any of the following social vulnerabilities?

Injecting drug use: ☐ Yes ☐ No ☐ Unknown
Specify drug if known:

Experiencing or at risk of homelessness: ☐ Yes ☐ No ☐ Unknown

Substance misuse: ☐ Yes ☐ No ☐ Unknown
Specify substance if known:

Experiencing or at risk of domestic and family violence: ☐ Yes ☐ No ☐ Unknown

Intellectual disability: ☐ Yes ☐ No ☐ Unknown

Mental illness: ☐ Yes ☐ No ☐ Unknown

Other (specify):

Please return this form to:

Queensland Syphilis Surveillance Service **South**:

Email (preferred): SQSSS@health.qld.gov.au **Secure fax**: (07) 3624 1188

If you require assistance with the management of infectious syphilis cases, please phone the Queensland Syphilis Surveillance Service on **1800 032 238** or contact your local Sexual Health Clinic.

Clinical Guidelines for the Management of Syphilis and other sexually transmissible infections are available from the sexual health guidelines website: https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/sex-health/guidelines