

A) PERSON REPORTING – HEALTH CARE PROVIDER INFORMATION

Clinic Name: Location: Attending Physician or Nurse: Address: Phone number:	FOR PUBLIC HEALTH OFFICE USE ONLY: Service Area: Date Received: Panorama Client ID: Panorama Investigation ID:
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B) CLIENT INFORMATION

Last Name:		First Name: and Middle Name:		Alternate Name:	
DOB: YYYY / MM / DD Age: _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other Gender Identity: <input type="checkbox"/> Transgender Male-to-female <input type="checkbox"/> Transgender Female-to-male <input type="checkbox"/> Undifferentiated <input type="checkbox"/> Other (specify)		Phone :	
Health Card Province: _____ Health Card Number (PHN):				<input type="checkbox"/> Primary Home: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> Workplace: <input type="checkbox"/> Alt Contact: Name: _____	
Place of Employment/School:		Email Address:		Relationship: _____	
Address Type: <input type="checkbox"/> No fixed <input type="checkbox"/> Postal Address <input type="checkbox"/> Primary Home <input type="checkbox"/> Temporary <input type="checkbox"/> Legal Land Description Mailing (Postal address): Street Address or FN Community (Primary Home):					
Is client pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		Online Names: Site/Service:		User name:	
Is case HIV positive? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes, If Yes, does the client disclose status to partners?				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	
Is case HB positive? <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes, If Yes, does the client disclose status to partners?				<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown	

C) IMMIGRATION INFORMATION

Country Born in: <input type="checkbox"/> Canada <input type="checkbox"/> Unknown <input type="checkbox"/> _____
Country Emigrated from: _____ Arrival Date: YYYY / MMM / DD OR Arrival Year _____

D) DISEASE EVENT HISTORY

Site / Presentation:	<input type="checkbox"/> Infectious	<input type="checkbox"/> Non-Infectious
Staging:	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Early latent <input type="checkbox"/> Early neurosyphilis (<1 year after infection)	<input type="checkbox"/> Late latent <input type="checkbox"/> Tertiary other than neurosyphilis <input type="checkbox"/> Late neurosyphilis (>1 year after infection)
	<input type="checkbox"/> Early congenital <input type="checkbox"/> Syphilitic stillbirth <input type="checkbox"/> Late congenital <input type="checkbox"/> Unknown	

Syphilis – Notification Form

Case Name: _____
Page _____ of _____

E) SIGNS & SYMPTOMS

Description	Yes Date of onset	Date of recovery	Description	Yes Date of onset	Date of recovery
Asymptomatic			Rash - trunk	YYYY / MM / DD	YYYY / MM / DD
Chancere - anal	YYYY / MM / DD	YYYY / MM / DD	Retinitis	YYYY / MM / DD	YYYY / MM / DD
Chancere - genital	YYYY / MM / DD	YYYY / MM / DD	Uveitis (inflammation of uvea)	YYYY / MM / DD	YYYY / MM / DD
Chancere - oral	YYYY / MM / DD	YYYY / MM / DD	Cardiac - aortic aneurysm	YYYY / MM / DD	YYYY / MM / DD
Lymphadenopathy: _____	YYYY / MM / DD	YYYY / MM / DD	Cardiac - aortic regurgitation	YYYY / MM / DD	YYYY / MM / DD
Alopecia (loss of normal hair distribution)	YYYY / MM / DD	YYYY / MM / DD	Cardiac - coronary artery - ostial stenosis	YYYY / MM / DD	YYYY / MM / DD
Condyloma lata	YYYY / MM / DD	YYYY / MM / DD	Dementia	YYYY / MM / DD	YYYY / MM / DD
Fever	YYYY / MM / DD	YYYY / MM / DD	Gumma - bone	YYYY / MM / DD	YYYY / MM / DD
Headache	YYYY / MM / DD	YYYY / MM / DD	Gumma - organs	YYYY / MM / DD	YYYY / MM / DD
Lesions - mucocutaneous or mucosal	YYYY / MM / DD	YYYY / MM / DD	Gumma - skin	YYYY / MM / DD	YYYY / MM / DD
Rash - palms	YYYY / MM / DD	YYYY / MM / DD	Vertigo	YYYY / MM / DD	YYYY / MM / DD
Rash - soles	YYYY / MM / DD	YYYY / MM / DD			
Other Signs & Symptoms, if applicable					

F) RISK FACTORS

DESCRIPTION	Yes	N –No NA – not asked U - unknown	DESCRIPTION	Yes	N –No NA – not asked U - unknown
Medical History - Previous STI			Sexual Behaviour - Victim of sexual assault		
Medical Treatment - Blood, blood product or tissue recipient (Add'l Info)			Sexual Behaviour - Unknown/ anonymous partner		
Sexual Behaviour E-partnering: internet or apps: (Add'l Info)			Special Population - Homeless		
Sexual Behaviour - Men who have sex with Men (MSM)			Special Population - Street involved		
Sexual Behaviour - More than 2 sexual partners in past 3 months			Substance Use - Alcohol		
Sexual Behaviour - No condom use			Substance Use - Illicit non-injection drug use		
Sexual Behaviour - Goods provided (food, shelter, money or drugs) in exchange for sex			Substance Use - Injection drug use (including steroids)		
Sexual Behaviour - Goods received (food, shelter, money or drugs) in exchange for sex			Travel – Outside of Canada: (Add'l Info)		
Sexual Behaviour - Sex with a known case (Add'l Info.)			Blood, blood product or tissue donor <small>Public Health to make referral to CBS</small>		

G) TREATMENT

Medical Order provided by: _____		Treated By: _____	
<input type="checkbox"/> Bicillin (2.4 million units once)	Date treated: YYYY / MM / DD		
<input type="checkbox"/> Bicillin (2.4 million units IM weekly x 2 weeks)	Date treated: YYYY / MM / DD	Date treated: YYYY / MM / DD	
<input type="checkbox"/> Bicillin (2.4 million units IM weekly x 3 weeks)	Date treated: YYYY / MM / DD	Date treated: YYYY / MM / DD Date treated: YYYY / MM / DD	
<input type="checkbox"/> Doxycycline 100mg bid x 14 days	Date treatment started: YYYY / MM / DD		
<input type="checkbox"/> Doxycycline 100mg bid x 28 days	Date treatment started: YYYY / MM / DD		
<input type="checkbox"/> Other:	Date treated: YYYY / MM / DD		

H) INFECTIOUS PERIOD (INCLUDE DATES FOR CONTACT TRACING)

Trace-back Periods: Primary – 3 months Secondary – 6 months Early Latent – 12 months Non-Infectious – Regular Partners

From: YYYY / MM / DD	to	YYYY / MM / DD
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I) UNKNOWN/ANONYMOUS CONTACTS

Anonymous contacts: _____ (number of sexual contacts that the individual cannot name)

Include known sexual contacts on the following pages

Syphilis Contacts – Notification Form

Traceback Periods: **Primary – 3 months, Secondary – 6 months, Early Latent – 12 months**
Non-Infectious Traceback Periods: **Late Latent – Regular Partners**

3) SEXUAL PARTNER INFORMATION

**** Please include information on additional contacts on a separate sheet**

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / DD Age: _____ HSN: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
Phone #: <input type="checkbox"/> Primary Home: <input type="checkbox"/> Workplace: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> Alternate phone:	Relationship:	e-mail Address:
Address Type: <input type="checkbox"/> No fixed <input type="checkbox"/> Postal Address <input type="checkbox"/> Primary Home <input type="checkbox"/> Temporary <input type="checkbox"/> Legal Land Description		
Street Address or FN Community (Primary Home):		
Online Names: Site/Service:	User name:	Place of Employment/School:
Exposure Dates: 1st YYYY / MMM / DD to YYYY / MMM / DD	Is contact pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Exposure Type: <input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Anal <input type="checkbox"/> Delivery/Perinatal	Is this person positive for an STI? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	HIV Positive: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	Hepatitis B Positive: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Will the testing Physician/Nurse follow-up this contact? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date contact notified: YYYY / MMM / DD Was treatment given? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: _____	Comments:	
Will index case be notifying contact <input type="checkbox"/> Yes <input type="checkbox"/> No		

4) SEXUAL PARTNER INFORMATION

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / DD Age: _____ HSN: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
Phone #: <input type="checkbox"/> Primary Home: <input type="checkbox"/> Workplace: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> Alternate phone:	Relationship:	e-mail Address:
Address Type: <input type="checkbox"/> No fixed <input type="checkbox"/> Postal Address <input type="checkbox"/> Primary Home <input type="checkbox"/> Temporary <input type="checkbox"/> Legal Land Description		
Street Address or FN Community (Primary Home):		
Online Names: Site/Service:	User name:	Place of Employment/School:
Exposure Dates: 1 st YYYY / MMM / DD to YYYY / MMM / DD	Is contact pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Exposure Type: <input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Anal <input type="checkbox"/> Delivery/Perinatal	Is this person positive for an STI? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	HIV Positive: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	Hepatitis B Positive: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Will the testing Physician/Nurse follow-up this contact? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date contact notified: YYYY / MMM / DD Was treatment given? <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: _____	Comments:	
Will index case be notifying contact <input type="checkbox"/> Yes <input type="checkbox"/> No		