Government of Saskatchewan

Syphilis Notification Form

Refer to SHA Practitioner Checklist

PANORAMA

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:** **Panorama QA complete:** ☐ **Yes** ☐ **No** **Initials:**

B) CLIENT INFORMATION

Last Name:	First Name and Middle Name:	Alternate Name:
DOB: YYYY / MM / DD Age: _____ Health Card Province: _____ Health Card Number (PHN):	**Gender**: ☐ Male ☐ Female ☐ Unknown ☐ Other **Gender Identity:** ☐ Transgender Male-to-female ☐ Transgender Female-to-male ☐ Undifferentiated ☐ Other (specify)	Phone : ☐ Primary Home: ☐ Mobile contact: ☐ Workplace: ☐ Alt Contact: Name: _____ Relationship: _____ Preferred Communication Method: ☐ Home ☐ Work ☐ E-mail ☐ Text
Place of Employment/School:	Email Address:	

Address Type: ☐ No fixed ☐ Postal Address ☐ Primary Home ☐ Temporary ☐ Legal Land Description

Mailing (Postal address):

Street Address or **FN Community** (Primary Home):

Is client pregnant? ☐ Yes ☐ No **EDD**: YYYY / MM / DD	**Online Names:** **Site/Service:** **User name:**

Is case HIV positive? ☐ No ☐ Yes ☐ Unknown If Yes, does the client disclose status to partners? ☐ No ☐ Yes ☐ Unknown

Is case Hep B positive? ☐ No ☐ Yes ☐ Unknown If Yes, does the client disclose status to partners? ☐ No ☐ Yes ☐ Unknown

C) IMMIGRATION INFORMATION

Country Born in: ☐ Canada ☐ Other (Specify) _____ ☐ Unknown

Country Emigrated from: _____ Arrival Date: YYYY / MM / DD OR Arrival Year_____

D) SIGNS & SYMPTOMS

	Description	If yes, date of onset		Description	If yes, date of onset
Primary	Chancre - anal	YYYY / MM / DD	**Neurosyphilis**	Clinical Signs of Early Neurosyphilis[1] < 1 year from dx Refer to ID	YYYY / MM / DD
Primary	Chancre - genital	YYYY / MM / DD			
Primary	Chancre - oral	YYYY / MM / DD		Clinical Signs of Late Neurosyphilis[2] > 1 year from dx	YYYY / MM / DD
Primary	Lymphadenopathy - regional	YYYY / MM / DD	**Early Latent**	Asymptomatic < 1year ☐	
Secondary	Alopecia	YYYY / MM / DD	**Late Latent**	Asymptomatic > 1year ☐	
Secondary	Condyloma lata	YYYY / MM / DD			
Secondary	Fever	YYYY / MM / DD	**Tertiary**	Cardiac - aortic aneurysm	YYYY / MM / DD
Secondary	Lesions - mucocutaneous or mucosal	YYYY / MM / DD		Cardiac - aortic regurgitation	YYYY / MM / DD
Secondary	Rash - palms	YYYY / MM / DD		Cardiac - coronary artery - ostial stenosis	YYYY / MM / DD
Secondary	Rash - soles	YYYY / MM / DD		Gumma - bone	YYYY / MM / DD
Secondary	Rash - trunk	YYYY / MM / DD		Gumma - organs	YYYY / MM / DD
Secondary	Malaise	YYYY / MM / DD		Gumma - skin	YYYY / MM / DD
Secondary	Headache	YYYY / MM / DD			
Secondary	Lymphadenopathy - generalized	YYYY / MM / DD			
Other Signs and Symptoms, if applicable:					YYYY / MM / DD

[1]Clinical signs of early neurosyphilis may include headache, dementia, retinitis, uveitis, sudden hearing loss/tinitis, vertigo.

[2]Clinical signs of late neurosyphilis may include headache, myelopathy (spinal cord disorder) tabes dorsalis, Argyll Robertson pupil, ataxia

Syphilis – Notification Form

E) DISEASE EVENT HISTORY

Site / Staging

☐ Infectious (specify)
- ☐ Primary
- ☐ Secondary
- ☐ Early latent
- ☐ Early neurosyphilis

☐ Non-infectious (specify)
- ☐ Late latent
- ☐ Late neurosyphilis
- ☐ Tertiary other than neurosyphilis

☐ Latent syphilis of Unknown Duration

F) TREATMENT (refer to SHA Maternal Clinical Protocols and Clinical Resources

Medical Order provided by: _____ **Treated By:** _____

☐ Bicillin (2.4 million units once) **Date treated:** YYYY / MM / DD

☐ Bicillin (2.4 million units IM weekly x 2 weeks) **Date treated:** YYYY / MM / DD **Date treated:** YYYY / MM / DD

☐ 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

☐ Doxycycline 100mg bid x 14 days **Date treatment started**: YYYY / MM / DD

☐ Doxycycline 100mg bid x 28 days **Date treatment started**: YYYY / MM / DD

☐ Other: **Date treated:** YYYY / MM / DD

G) RISK FACTORS

DESCRIPTION	☐ Yes	☐ No	☐ Unknown	☐ Not asked
Immunocompromised - HIV+	☐	☐	☐	☐
Medical History	☐	☐	☐	☐
Previous STI (if yes, specify which infection and when)	☐	☐	☐	☐
Sexual Behaviour	☐	☐	☐	☐
E-partnering: internet or apps: (Add'l Info) Include the names of the website or apps	☐	☐	☐	☐
Men who have sex with Men (MSM)	☐	☐	☐	☐
Events with multiple sexual partners (party and play)	☐	☐	☐	☐
More than 2 sexual partners in past 3 months	☐	☐	☐	☐
No condom use	☐	☐	☐	☐
Goods **provided** (food, shelter, money or drugs) in exchange for sex	☐	☐	☐	☐
Goods **received** (food, shelter, money or drugs) in exchange for sex	☐	☐	☐	☐
Sex with a known case (Add'l Info.) Include the name of the case	☐	☐	☐	☐
Victim of sexual assault (as the source of infection)	☐	☐	☐	☐
Unknown/anonymous partner	☐	☐	☐	☐
Social Determinants of Health	☐	☐	☐	☐
Does not have a regular physician or health care provider	☐	☐	☐	☐
Special Population	☐	☐	☐	☐
Correctional facility resident (i.e. inmate)	☐	☐	☐	☐
Homeless	☐	☐	☐	☐
Street involved	☐	☐	☐	☐
Pregnancy (Add'l Info) EDD: YYYY / MM / DD	☐	☐	☐	☐
Substance Use	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Illicit non-injection drug use	☐	☐	☐	☐
Injection drug use (including steroids)	☐	☐	☐	☐
Travel Outside of Canada: (Add'l Info) Specify where and when travel occurred	☐	☐	☐	☐
Medical Treatment	☐	☐	☐	☐
Blood, blood product or tissue recipient (Add'l Info) Specify where and when receipt occurred	☐	☐	☐	☐
Blood, blood product or tissue **donor** Public Health to make referral to CBS	☐	☐	☐	☐

H) INFECTIOUS PERIOD (INCLUDE DATES FOR CONTACT TRACING)

Trace-back Periods (see pg 3): Primary – *3 months* Secondary – *6 months* Early Latent – *12 months* Non-Infectious – *Regular Partners*

From: YYYY / MM / DD to YYYY / MM / DD

I) UNKNOWN/ANONYMOUS CONTACTS

LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> TE HYPERLINK -> UNKNOWN/ANONYMOUS CONTACTS

Anonymous contacts:_____ (number of sexual contacts that the individual cannot name) PH – Create a transmission event

Include known sexual contacts on the following pages

Syphilis Contacts – Notification Form

Traceback Periods: **Primary – 3 months from onset of symptoms, Secondary – 6 months from onset of symptoms, Early Latent – 12 months from date of diagnosis**
Non-Infectious Traceback Periods: Late Latent – Regular Partners
Perinatal contacts – complete Notification of Infant Born to a Woman Infected With Syphilis During Pregnancy

1) SEXUAL CONTACT INFORMATION ** Please include information on additional contacts on a separate sheet

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

2) SEXUAL CONTACT INFORMATION

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