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|  | | | | | **Syphilis Enhanced Surveillance Form**  Version 15  CONFIDENTIAL | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | |
| CIDR ID: | | | | | | | | | | | | | | | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | |
| **A. Case Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Patient Clinic ID | | | | | Click or tap here to enter text. | | | | | | | |  | | | Clinic/Practice Name | | | | | | | | Click or tap here to enter text. | | | | | | | | |  |
|  | Lab specimen ID | | | | | Click or tap here to enter text. | | | | | | | |  | | | Laboratory name | | | | | | | | Click or tap here to enter text. | | | | | | | | |  |
|  | Forename | | | | | Click or tap here to enter text. | | | | | | | |  | | | Surname | | | | | | | | Click or tap here to enter text. | | | | | | | | |  |
|  | Date of birth | | | | | Click or tap to enter a date. | | | | | | | |  | | |  | | | | | | | |  | | | | | | | | |  |
|  | Sex (at birth) | | | | | Male | | | | | | Female | | | | | | | | | Unknown | | | | | | | | | |  | | |  |
|  | Gender identity | | | | | Male | | | | | | Female | | | | | | | | | Nonbinary | | | | | | | Unknown | | | | | |  |
|  |  | | | | | Trans male | | | | | | Trans female | | | | | | | | |  | | | | | | |  | | | | | |  |
|  | **Note: please complete sex (assigned at birth) and gender identity for all cases. A trans male refers to person who identifies as male and was assigned female at birth. A trans female refers to a person who identifies as female and was assigned male at birth. Non-binary refers to a person who does not identify as being exclusively female or male.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | |  | | | | | | |  | | | | | |  | | | | |  | | | | |  |
|  | Country of birth | | | | | Choose an item. | | | | | | | | County of residence | | | | | | | | | | | Choose an item. | | | | | | | | |  |
|  | Ethnicity | | | | | White – Irish | | | | | | | | | | | | | | Asian or Asian Irish - Chinese | | | | | | | | | | | | | |  |
|  |  | | | | | White – Irish Traveller | | | | | | | | | | | | | | Asian or Asian Irish – Indian/Pakistani/Bangladeshi | | | | | | | | | | | | | |  |
|  |  | | | | | White – Any other white background | | | | | | | | | | | | | | Asian or Asian Irish – Any other Asian background | | | | | | | | | | | | | |  |
|  |  | | | | | Black or Black Irish - African | | | | | | | | | | | | | | Arabic | | | | | | | | | | | | | |  |
|  |  | | | | | Black or Black Irish – Any | | | | | | | | | | | | | | Roma | | | | | | | | | | | | | |  |
|  |  | | | | | Mixed background | | | | | | | | | | | | | | Other | | | | | | | | | | | | | |  |
|  |  | | | | | Not known | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  |
| **Note: ethnicity should be self-reported and refers to how the individual case identifies themselves.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | **B. Clinical Details** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Mode of transmission | | | | | | | | Heterosexual | | | gbMSM | | | | | | | Unknown | | | | | | | | | | | | | | | |
|  |  | | | | | | | | Other. If other mode of transmission, please specify | | | | | | | | | | | | | | Click or tap here to enter text. | | | | | | | | | | |  |
|  | Country of infection | | | | | | Choose an item. | | | | | | | | |  | | | | | | | | | | | | | | | | | | |
|  | HIV status? | | | | | | | | Positive  Negative  Unknown | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | If HIV negative, was the patient taking HIV pre-exposure prophylaxis at the time of syphilis diagnosis? | | | | | | | | | | | | | Yes  No  Unknown | | | | | | | | | | | | | | | | | | |
|  | Does the patient have symptoms of syphilis? | | | | | | | | | | | | |  | | Yes  No  Unknown | | | | | | | | | | | | | | | | | | |
|  | Is the patient a commercial sex worker (CSW)? | | | | | | | | | | | | |  | | Yes  No  Unknown | | | | | | | | | | | | | | | | | | |
|  | Did the patient have contact with a CSW? | | | | | | | | | | | | |  | | Yes  No  Unknown | | | | | | | | | | | | | | | | | | |
|  | **C. Case classification (please select one)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Confirmed case (patient meets the clinical and laboratory criteria) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Probable case (patient is symptomatic but does not meet the laboratory criteria) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **D. For cases diagnosed in pregnancy** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Is the patient pregnant?  Yes  No  Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | | **If yes, please complete rest of this section. If no, proceed to section E.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | | Patient diagnosed as a result of antenatal screening?  Yes  No  Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | |  | | If yes, gestation at screening | | | | | | Click or tap here to enter text. | | | | | | | | | | | | /40 | | | | | | | | | | |  | |
|  | | History of treated syphilis prior to pregnancy?  Yes  No  Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | | For this pregnancy, date syphilis treatment completed | | | | | | | | | | | | | Click or tap to enter a date. | | | | | | | | | | | |  | | | | | |  | |
|  | | Pregnancy outcome  Live birth  Stillbirth  Miscarriage  Termination | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | | Gestation at birth | | | | | | Click or tap here to enter text. | | | | | /40 | | | | | | | | | | | | | | | | | | | |  | |
|  | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  |  | |
|  | | Maternity hospital | | | | | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | |  |  | |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | | **E. Comments** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
|  | | Click or tap here to enter text. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| **F. Form Completed by**   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Completed by | Click or tap here to enter text. | | | |  | Date | Click or tap to enter a date. |  | | Position | Doctor | Nurse | Public health | Health advisor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Please return the completed form to your local Department of Public Health.

See <http://www.hpsc.ie/NotifiableDiseases/Whotonotify/> for names and contact details. If sending by post, please place form in a sealed envelope marked “Private and Confidential”.

A separate form is available from <https://www.hpsc.ie/a-z/sexuallytransmittedinfections/syphilis/surveillanceforms/> for congenital cases

See <https://www.hpsc.ie/a-z/sexuallytransmittedinfections/syphilis/> for syphilis case definition.