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|  | **Syphilis Enhanced Surveillance Form**Version 16CONFIDENTIAL |  |
| CIDR ID: |  |
| **A. Case Details** |
|  | Patient Clinic ID |  |  | Clinic/Practice Name |  |  |
|  | Lab specimen ID |  |  | Laboratory name |  |  |
|  | Forename |  |  | Surname |  |  |
|  | Date of birth |  |  |  |  |  |  |  |  |  |  |
|  | Sex (at birth) | [ ]  Male | [ ]  Female | [ ]  Unknown |  |  |
|  | Gender identity | [ ]  Male | [ ]  Female | [ ]  Nonbinary | [x]  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 |  | County of residence |  |  |
|  | 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 |  |  |
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|  **Note: ethnicity should be self-reported and refers to how the individual case identifies themselves.** |

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|  | **B. Clinical Details** |
|  | Mode of transmission | [ ]  Heterosexual  | [ ]  gbMSM | [ ]  Unknown |
|  |  | [ ]  Other. If other mode of transmission, please specify |  |  |
|  | Country of infection |  |  |
|  | 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)[ ]  Confirmed case-reinfection (patient has a four-fold increase in RPR as documented by clinic)  |
|  | [ ]  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  |  |  | /40  |  |
|  | History of treated syphilis prior to pregnancy? [ ]  Yes [ ]  No [ ]  Unknown |  |
|  | For this pregnancy, date syphilis treatment completed |  |  |  |  |  |  |  |  |
|  | Pregnancy outcome [ ]  Live birth [ ]  Stillbirth [ ]  Miscarriage [ ]  Termination |  |
|  | Gestation at birth  |  |  | /40 |  |
|  |  |  |  |  |
|  | Maternity hospital  |  |  |  |
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|  | **E. Comments** |  |
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| **F. Form Completed by**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Completed by  |  |  | Date  |  |  |  |  |  |  |  |
|
| Position  | [ ]  Doctor | [ ]  Nurse | [ ]  Public health | [ ]  Health advisor |

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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.