Syphilis Enhanced Surveillance Form

Version 16

CONFIDENTIAL

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 ☒ 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
☐ White – Irish Traveller
☐ White – Any other white background
☐ Black or Black Irish - African
☐ Black or Black Irish – Any
☐ Mixed background
☐ Not known
☐ Asian or Asian Irish - Chinese
☐ Asian or Asian Irish – Indian/Pakistani/Bangladeshi
☐ Asian or Asian Irish – Any other Asian background
☐ Arabic
☐ Roma
☐ Other

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

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

E. Comments

F. Form Completed by

Completed by _____ 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.