

Syphilis Notification Form

Refer to [SHA Practitioner Checklist](#)

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: _____
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B) CLIENT INFORMATION

Last Name: _____	First Name and Middle Name: _____	Alternate Name: _____
DOB: ____ / ____ / ____ Age: ____	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: _____
Health Card Province: _____ Health Card Number (PHN): _____		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: ____ / ____ / ____	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: ____ / ____ / ____ OR Arrival Year: _____

D) SIGNS & SYMPTOMS

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

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

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

Syphilis – Notification Form

Case Name: _____
Page _____ of _____

E) DISEASE EVENT HISTORY

Site / Staging	
☐ Infectious (specify) ☐ Primary ☐ Secondary	☐ Non-infectious (specify) ☐ Early latent ☐ Early neurosyphilis ☐ 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 recipient 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
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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
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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: _____		Gender: ☐ Male ☐ Female ☐ Unknown ☐ Other			
HSN: _____					
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			Is contact pregnant? ☐ Yes ☐ No ☐ Unknown		
Exposure Type: ☐ Vaginal ☐ Oral ☐ Anal			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: _____		Gender: ☐ Male ☐ Female ☐ Unknown ☐ Other			
HSN: _____					
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			Is contact pregnant? ☐ Yes ☐ No ☐ Unknown		
Exposure Type: ☐ Vaginal ☐ Oral ☐ Anal			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:		