Government of Saskatchewan

Syphilis Notification Form

PANORAMA

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

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:**

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	**Online Names:** **Site/Service:** **User name:**

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

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

C) IMMIGRATION INFORMATION

Country Born in: ☐ Canada ☐ Unknown ☐ _____

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

D) DISEASE EVENT HISTORY

Site / Presentation: ☐ Infectious ☐ Non-Infectious

Staging:

☐ Primary
☐ Secondary
☐ Early latent
☐ Early neurosyphilis (<1 year after infection)
☐ Late latent
☐ Tertiary other than neurosyphilis
☐ Late neurosyphilis (>1 year after infection)
☐ Early congenital
☐ Syphilitic stillbirth
☐ Late congenital
☐ Unknown

Syphilis – Notification Form

E) SIGNS & SYMPTOMS

Description	Yes Date of onset	Date of recovery	Description	Yes Date of onset	Date of recovery
Asymptomatic			Rash - trunk	YYYY / MM / DD	YYYY / MM / DD
Chancre - anal	YYYY / MM / DD	YYYY / MM / DD	Retinitis	YYYY / MM / DD	YYYY / MM / DD
Chancre - genital	YYYY / MM / DD	YYYY / MM / DD	Uveitis (inflammation of uvea)	YYYY / MM / DD	YYYY / MM / DD
Chancre - oral	YYYY / MM / DD	YYYY / MM / DD	Cardiac - aortic aneurysm	YYYY / MM / DD	YYYY / MM / DD
Lymphadenopathy: _____	YYYY / MM / DD	YYYY / MM / DD	Cardiac - aortic regurgitation	YYYY / MM / DD	YYYY / MM / DD
Alopecia (loss of normal hair distribution)	YYYY / MM / DD	YYYY / MM / DD	Cardiac - coronary artery - ostial stenosis	YYYY / MM / DD	YYYY / MM / DD
Condyloma lata	YYYY / MM / DD	YYYY / MM / DD	Dementia	YYYY / MM / DD	YYYY / MM / DD
Fever	YYYY / MM / DD	YYYY / MM / DD	Gumma - bone	YYYY / MM / DD	YYYY / MM / DD
Headache	YYYY / MM / DD	YYYY / MM / DD	Gumma - organs	YYYY / MM / DD	YYYY / MM / DD
Lesions - mucocutaneous or mucosal	YYYY / MM / DD	YYYY / MM / DD	Gumma - skin	YYYY / MM / DD	YYYY / MM / DD
Rash - palms	YYYY / MM / DD	YYYY / MM / DD	Vertigo	YYYY / MM / DD	YYYY / MM / DD
Rash - soles	YYYY / MM / DD	YYYY / MM / DD			
Other Signs & Symptoms, if applicable					

F) RISK FACTORS

DESCRIPTION	Yes	N –No NA – not asked U - unknown	DESCRIPTION	Yes	N –No NA – not asked U - unknown
Medical History - Previous STI			**Sexual Behaviour** - Victim of sexual assault		
Medical Treatment - Blood, blood product or tissue recipient (Add'l Info)	TE		**Sexual Behaviour** - Unknown/ anonymous partner		
Sexual Behaviour E-partnering: internet or apps: (Add'l Info)			**Special Population** - Homeless		
Sexual Behaviour - Men who have sex with Men (MSM)			**Special Population** - Street involved		
Sexual Behaviour - More than 2 sexual partners in past 3 months			**Substance Use** - Alcohol		
Sexual Behaviour - No condom use			**Substance Use** - Illicit non-injection drug use		
Sexual Behaviour - Goods **provided** (food, shelter, money or drugs) in exchange for sex			**Substance Use** - Injection drug use (including steroids)		
Sexual Behaviour - Goods **received** (food, shelter, money or drugs) in exchange for sex			**Travel** – Outside of Canada: (Add'l Info)		
Sexual Behaviour - Sex with a known case (Add'l Info.)			Blood, blood product ortissue **donor** Public Health to make referral to CBS		

G) TREATMENT

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

H) INFECTIOUS PERIOD (INCLUDE DATES FOR CONTACT TRACING)

Trace-back Periods: 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

Anonymous contacts:_____ (number of sexual contacts that the individual cannot name)

Include known sexual contacts on the following pages

Case Name:

Page _____ of _____

Syphilis Contacts – Notification Form

Traceback Periods: **Primary – 3 months, Secondary – 6 months, Early Latent – 12 months**
Non-Infectious Traceback Periods: **Late Latent – Regular Partners**

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 / MMM / 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 / MMM / DD to YYYY / MMM / DD **Exposure** Type: ☐ Vaginal ☐ Oral ☐ Anal ☐ Delivery/Perinatal	**Is contact pregnant?** ☐ Yes ☐ No ☐ Unknown **Is this person positive for an STI?** ☐ Yes ☐ No ☐ Unknown **HIV Positive:** ☐ Yes ☐ No ☐ Unknown **Hepatitis B Positive:** ☐ Yes ☐ No ☐ Unknown	
Will the testing Physician/Nurse **follow-up** this contact? ☐ Yes ☐ No If yes, date contact notified: YYYY / MMM / DD Was treatment given? ☐ Yes ☐ No Specify: _____ Will index case be notifying contact ☐ Yes ☐ No	**Comments**:	

2) SEXUAL PARTNER INFORMATION

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / 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 / MMM / DD to YYYY / MMM / DD **Exposure** Type: ☐ Vaginal ☐ Oral ☐ Anal ☐ Delivery/Perinatal	**Is contact pregnant?** ☐ Yes ☐ No ☐ Unknown **Is this person positive for an STI?** ☐ Yes ☐ No ☐ Unknown **HIV Positive:** ☐ Yes ☐ No ☐ Unknown **Hepatitis B Positive:** ☐ Yes ☐ No ☐ Unknown	
Will the testing Physician/Nurse **follow-up** this contact? ☐ Yes ☐ No If yes, date contact notified: YYYY / MMM / DD Was treatment given? ☐ Yes ☐ No Specify: _____ Will index case be notifying contact ☐ Yes ☐ No	**Comments**:	

Case Name:

Page _____ of _____

Syphilis Contacts – Notification Form

Traceback Periods: **Primary – 3 months, Secondary – 6 months, Early Latent – 12 months**
Non-Infectious Traceback Periods: **Late Latent – Regular Partners**

3) SEXUAL PARTNER INFORMATION

**** Please include information on additional contacts on a separate sheet**

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / 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:	
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4) SEXUAL PARTNER INFORMATION

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / 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 / MMM / DD to YYYY / MMM / DD **Exposure** Type: ☐ Vaginal ☐ Oral ☐ Anal ☐ Delivery/Perinatal	**Is contact pregnant?** ☐ Yes ☐ No ☐ Unknown **Is this person positive for an STI?** ☐ Yes ☐ No ☐ Unknown **HIV Positive:** ☐ Yes ☐ No ☐ Unknown **Hepatitis B Positive:** ☐ Yes ☐ No ☐ Unknown	
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