SYPHILIS CASE REPORT

NORTH DAKOTA DEPARTMENT OF HEALTH
DISEASE CONTROL SECTION
SFN 61082 (02/2021)

The North Dakota Department of Health (NDDoH) Disease Control Section requires the following information to be reported on all syphilis cases. This form shall be used for all newly diagnosed syphilis cases.

Required Patient Demographic Information:

First Name	*Last Name*	*Date of Birth*	
Street Address	*City*	*State*	*ZIP Code*
Telephone Number:	*Assigned sex at birth:* ☐ Male ☐ Female		
Current Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Transgender Unspecified ☐ Another Gender ☐ Declined to Answer			
Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Refused		*Ethnicity:* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused	
Pregnancy Status: ☐ Not Pregnant ☐ Pregnant ☐ NA		If Pregnant, Due Date:	
Was case tested for HIV? ☐ Yes ☐ No	If Yes: Collection Date:	*Result*: ☐ Positive ☐ Negative	
Was case tested for Chlamydia? ☐ Yes ☐ No Specimen Sources (Check All That Apply): ☐ Urine ☐ Cervix/Vaginal ☐ Rectum ☐ Pharyngeal	If Yes: Collection Date:	*Result*: ☐ Positive ☐ Negative *Positive Source(s):*	
Was case tested for Gonorrhea? ☐ Yes ☐ No Specimen Sources (Check All That Apply): ☐ Urine ☐ Cervix/Vaginal ☐ Rectum ☐ Pharyngeal	If Yes: Collection Date:	*Result*: ☐ Positive ☐ Negative *Positive Source(s):*	

Stage of Diagnosis

What is Patient's Diagnosed Stage of Syphilis?

- ☐ Primary Syphilis *(Characterized by the presence of one or more ulcerative lesions (e.g. chancre))*
- ☐ Secondary Syphilis *(Characterized by localized or diffuse mucocutaneous lesions (e.g. rash), often with generalized lymphadenopathy)*
- ☐ Early Syphilis *(No symptoms present, initial infection must have occurred within the previous 12 months)*
- ☐ Latent Syphilis (*No symptoms present, initial infection must have occurred greater than 12 months previously)*

Current and Past Symptoms

Did the patient have or ever had any of the following symptoms:	**Onset Date**	**Observed By Healthcare Provider**	**Duration (# of Days)**	**Additional Description**
Chancre ☐ Yes ☐ No	___/___/___	☐ Yes ☐ No		
Sore/Lesion ☐ Yes ☐ No	___/___/___	☐ Yes ☐ No		
Skin Rash ☐ Yes ☐ No	___/___/___	☐ Yes ☐ No		
Alopecia ☐ Yes ☐ No	___/___/___	☐ Yes ☐ No		
Condyloma lata ☐ Yes ☐ No	___/___/___	☐ Yes ☐ No		
Mucous Patches ☐ Yes ☐ No	___/___/___	☐ Yes ☐ No		
Other Manifestations: ☐ Neurological ☐ Ocular ☐ Otic	___/___/___	☐ Yes ☐ No		
Other Symptoms:	___/___/___	☐ Yes ☐ No		

Provider Information

Diagnosing HealthCare Provider:	
Facility:	*Telephone Number:*

Testing Information

Reason Test Conducted: ☐ Infection ☐ Screen ☐ Partner Referral		
Did case have history of syphilis testing? ☐ Yes ☐ No	*If Yes, collection date, test type & results:*	
Specimen Collection Date:	*Testing Laboratory:*	
Testing Note: Need both a non-treponemal and treponemal test to confirm syphilis.		
Was a non-treponemal (RPR or VDRL) test performed? ☐ Yes ☐ No	*If yes, which test was performed?* ☐ RRP ☐ VDRL (Source: ☐ Blood ☐ CSF)	RPR Titer 1:_____ VDRL Titer 1:_____
Was a treponemal (ex TPPA) test performed? ☐ Yes ☐ No	*If yes, which test was performed?* ☐ TPPA ☐ FTA-ABS ☐ Trep EIA	*If yes, results?* **TPPA**: ☐ Reactive ☐ Non-Reactive **FTA-ABS**: ☐ Reactive ☐ Non-Reactive **Trep EIA:** ☐ Reactive ☐ Non-Reactive

Treatment Information

Was treatment given for this infection? ☐ Yes ☐ No			
Syphilis Treatment: ☐ Benzathine penicillin G (Bicillin L-A) 2.4 million units IM in a single dose ☐ Benzathine penicillin G (Bicillin L-A) 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals		☐ Doxycycline, 100 mg PO BID * 14 days ☐ Doxycycline, 100 mg PO BID * 28 days ☐ Other_____	
Date of First Dose of Bicillin L-A:	*Date of Second Dose of Bicillin L-A:*	*Date of Third Dose of Bicillin L-A:*	*Treatment Date (if prescribed Doxy):*
If not observed, what pharmacy was prescription sent to?			
Was follow up appointments made? ☐ Yes ☐ No	*If yes, date(s) of follow-up:*		

Did the patient have or ever had any of the following risk factors?

Does the patient have a history of STI infections?	☐ Yes	☐ No	
Is the patient resident/staff of correctional facility?	☐ Yes	☐ No	
Has patient used intravenous/injection drugs?	☐ Yes	☐ No	
Has patient used non-injection drugs?	☐ Yes	☐ No	
Has the patient had sex while high/intoxicated?	☐ Yes	☐ No	
Has the patient had sex with an injection drug user?	☐ Yes	☐ No	
Has the patient traded sex for drugs or money?	☐ Yes	☐ No	
Has the patient had sex with an anonymous sex partner?	☐ Yes	☐ No	
Has the patient ever met sexual partners on the internet?	☐ Yes	☐ No	
Total number of sex partners in last 12 months:			
*Number of **Female** Partners*			
*Number of **Male** Partners*			
*Number of **Transgender** Partners*			
What types of sex has the patient had?	☐ Vaginal	☐ Oral, unspecified ☐ Oral, perform ☐ Oral, receive	☐ Anal, unspecified ☐ Anal, top ☐ Anal, bottom
How frequently does the patient use condoms during sex?	☐ Always ☐ Most of the time	☐ Half the time ☐ Not that often	☐ Never

Syphilis Partner History *Duplicate Syphilis Partner History form for additional partners *

*Sex partners of persons with syphilis are considered at risk for infection and should be confidentially notified of the exposure and need for evaluation. The NDDoH will notify sex partners. Partners who should be notified include those who have had sexual contact within 1) 3 months plus the duration of symptoms with persons diagnosed with **Primary Syphilis**, 2) 6 months plus duration of symptoms with those diagnosed with **Secondary Syphilis** and 3) 1 year with those diagnosed with **Early or Late Latent Syphilis**.*

Partner Name:	Date of Birth or Approximate Age:		Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Another Gender
Address:	City:	State:	Telephone Number:
Email Address/Phone Apps/Social Media Identifier (ex. Facebook ID):			
Date of First Exposure:		Frequency of Exposure:	
Date of Last Exposure:		Note for Exposure Dates: Include approximate dates if exact date unknown.	
Did confirmed case recall symptoms (i.e. lesions, rash, etc) on partner? ☐ Yes ☐ No			
If yes, describe partner symptoms (include date):			
Partner Specimen Collection Date:			Results:
Partner Treatment:			Treatment Date:

Partner Name:	Date of Birth or Approximate Age:		Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Another Gender
Address:	City:	State:	Telephone Number:
Email Address/Phone Apps/Social Media Identifier (ex. Facebook ID):			
Date of First Exposure:		Frequency of Exposure:	
Date of Last Exposure:		Note for Exposure Dates: Include approximate dates if exact date unknown.	
Did confirmed case recall symptoms (i.e. lesions, rash, etc) on partner? ☐ Yes ☐ No			
If yes, describe partner symptoms (include date):			
Partner Specimen Collection Date:			Results:
Partner Treatment:			Treatment Date:

Partner Name:	Date of Birth or Approximate Age:		Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Another Gender
Address:	City:	State:	Telephone Number:
Email Address/Phone Apps/Social Media Identifier (ex. Facebook ID):			
Date of First Exposure:		Frequency of Exposure:	
Date of Last Exposure:		Note for Exposure Dates: Include approximate dates if exact date unknown.	
Did confirmed case recall symptoms (i.e. lesions, rash, etc) on partner? ☐ Yes ☐ No			
If yes, describe partner symptoms (include date):			
Partner Specimen Collection Date:			Results:
Partner Treatment:			Treatment Date:

Please Fax Completed Forms to 701.328.0355. Contact NDDoH at 701.328.2378 for any questions.

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