Syphilis

ORPHEUS ID

☐Confirmed ☐ Under investigation ☐ Presumptive

Date of report ___/___/___ Assigned to: _____

Name_____ County_____
Last, First, Initials (a.k.a)

Address_____ E-mail_____
Street City Zip

Phone number _____ / _____
Home (H), work(W), cell(C), message(M) Home (H), work(W), cell(C), message(M)

ALTERNATE CONTACT _____

Name_____ Phone(s)_____
Last, First, Initials Home (H), work(W), cell(C), message(M)

DEMOGRAPHICS

DOB ____/___/___ If DOB unk, AGE___ Sex: ☐ Female ☐ Male ☐ Other:_____

Language_____ Phone(s) _____

Pregnancy ☐ Y ☐ N ☐ Unk
Due date __/__/__ or (# wks)

Past year housing (check one): ☐ Stably housed ☐ Unstably housed ☐ Homeless ☐ Incarcerated ☐ Declined ☐ Unk

Housing at Diagnosis (check one): ☐ Stably housed ☐ Unstably housed ☐ Homeless ☐ Incarcerated ☐ Declined ☐ Unk

RACE, ETHNICITY, LANGUAGE, AND DISABILITY (REALD)

How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry? _____

Which of the following best describes your racial or ethnic identity? Check **all** that apply

Amer Indian/ Alaska Native
- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis First Nation
- ☐ Indigenous Mexican Central American South American

Hispanic or Latino/a/x
- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ [illegible]

If you selected more than one racial or ethnic identity, circle the one that **best** represents your racial or ethnic identity. If you have **more than one** primary racial or ethnic identity, please check here ☐

Native Hawaiian/ Pacific Islander
- ☐ Guamanian
- ☐ Chamorro
- ☐ Micronesian/Marshallese/Palaun (COFA)
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Black or African American
- ☐ African American
- ☐ African (Black)
- ☐ Caribbean (Black)

Middle Eastern Northern African
- ☐ Northern African
- ☐ Middle Eastern

White
- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

Other Categories
- ☐ Other (please list) _____
- ☐ Don't know
- ☐ Don't want to answer

PROVIDERS, FACILITIES AND LABS (COMPLETE ALL THAT APPLY)

Reporter Type / Name / Phone: _____

Ordering provider (if different) _____

NOTES

LABORATORY DATA

Lab Name:_____ Collection date:___/___/___ Result date:___/___/___

Blood: Test Types (different test names)

☐RPR (*RPR Ser Ql*, *RPR Ser Titr, RPR Titer*):_____

☐VDRL: (*VDRL Ser Ql, VDRL Quantitative)* :_____

☐FTA (*FTA-ABS*, *T pallidum Ab Ser Ql IF*) :_____

☐TPPA (*TPPA*, *T pallidum Ab Ser Ql Aggl)* :_____

☐Trep AB 1 and Trep AB 2 (*Syphilis TP*, *T pallidum Ab Ser Ql*, *T pallidum Ab Ser Ql IA*, *T pallidum IgG+IgM Ser Ql IA*) :_____

☐DBS (dried blood spot) and rapid syphilis tests are treponemal tests.

CSF: Test Types and Results

☐VDRL_____

☐FTA_____

☐Protein _____

☐WBC_____

Lesion: Test Types and Results

☐Darkfield_____

CLINICAL DATA

Symptomatic? ☐yes ☐no ☐unknown If yes, onset date (first s/s) ____/____/____

Common symptoms of syphilis

☐Y ☐N ☐U Clinician observed lesion If yes, where_____

☐Y ☐N ☐U Chancre

☐Y ☐N ☐U Rash

☐Y ☐N ☐U Lymphadenopathy

☐Y ☐N ☐U Alopecia

☐Y ☐N ☐U Mucous Patches

☐Y ☐N ☐U Neurologic manifestations if yes, _____

☐Y ☐N ☐U Ocular manifestations If yes, _____

☐Y ☐N ☐U Otic manifestations If yes, _____

☐Y ☐N ☐U Late clinical manifestations If yes, _____

HIV status: ☐Positive ☐Negative ☐Unknown HIV test date __/__/___

☐Y ☐N ☐U Tested for CT/GC

PATIENT TREATMENT (FROM PROVIDER OR CASE INTERVIEW)

TREATMENT			
Treatment 1 Date ___/___/___ Drug: ☐Pen G LA ☐Doxy ☐Aqueous crystalline	Size (mg) _____	Dose _____	Frequency/duration _____
Treatment 2 Date ___/___/___ Drug: ☐Pen G LA ☐Doxy ☐Aqueous crystalline	Size (mg) _____	Dose _____	Frequency/duration _____
Treatment Date ___/___/___ Drug: ☐Pen G LA ☐Doxy ☐Aqueous crystalline	Size (mg) _____	Dose _____	Frequency/duration _____

NOTES

PATIENT EXPOSURES AND RISKS (BASED ON CASE INTERVIEW OR FROM PROVIDER IF AVAILABLE)		
Interviewed? ☐Y ☐N ☐R 1st call try __/__/__ Date Interviewed: __/__/___ by_____ If not, reason_____ ☐ not indicated ☐ unable to reach ☐ out of jurisdiction ☐ deceased ☐ refused ☐ medical records review ☐ physician interviewed		
Have any of your partners in the past 12 months been?	☐Female ☐male ☐TGM ☐TGF ☐R ☐U	
Total number of sex partners, in the past 12 months	The sum all sexual partners #_____	
Had sex with an anonymous partner within past 12 months?	☐Y ☐N ☐R ☐U	
Had sex with a person known to him/her to inject drugs (PWID) within the past 12 months?	☐Y ☐N ☐R ☐U	
Had sex while intoxicated and/or high on drugs withing past 12 months?	☐Y ☐N ☐R ☐U	
Engaged in injection (recreational) drug use within past 12 months?	☐Y ☐N ☐R ☐U If yes, name(s)_____	
Engaged in non-injection (recreational) drug use within past 12 months?	☐Y ☐N ☐R ☐U If yes, name(s)_____	
Had this person been incarcerated within the past 12 months?	☐Y ☐N ☐R ☐U	
Have you exchanged sex for a need within the past 12 months?	☐Y ☐N ☐R ☐U	
If yes, ☐money ☐drugs ☐paid bills ☐material goods ☐place to stay/sleep ☐food vehicle/transportation ☐dependent care security/protection other need(s)_____		
Had this person find partners through the internet apps, in the past 12 months?	☐Y ☐N ☐R ☐U If yes, name(s):_____	
Have you ever taken PrEP for HIV prevention?	☐Y ☐N ☐R ☐U if yes, date ___/____/____	
Are there challenges to continue PrEP?	☐Y ☐N ☐R ☐U If yes, what:_____	
Are there challenges to start PrEP?	☐Y ☐N ☐R ☐U If yes, what:_____	
Have you taken PEP for HIV prevention?		
If pregnant: Yes		
Did you use any of the following services during your most recent pregnancy?	☐ WIC ☐ Visiting nurse program ☐ Homeless shelter ☐ Syringe services program ☐ Individual counseling ☐ Group counseling Food bank ☐ Visits from homeless services & outreach including street medicine	☐ Peer support program (PSP) for pregnant person ☐ PSP for persons who use substances ☐ PSP for person with mental health challenges ☐ Services offered by cultural/religious organizations (church/house of worship)
What if any of the following resources did you receive during your most recent pregnancy?	☐ WIC ☐ SNAP ☐ SSI – supplemental security income ☐ Social security ☐ HCV – Housing choice voucher program, section 8 or HUD	☐ Public housing ☐ Unemployment ☐ Visiting nurse program ☐ Other_____ ☐ NA

CONTACTS

Ask about contacts (sexual, needle-sharing, etc.) within the appropriate interview period for the syphilis stage. List below name and contact information for all contacts. Duplicate this page as necessary., For each contact, complete a copy of the contact interview form (page 4). ☐No contacts elicited ☐No contacts initiated

Date partner named__/__/__ Partner age or date or birth __/__/__ Sex ☐female ☐male ☐TGF ☐TGM ☐unknown Email _____ Name_____ Phone(s)_____ AKA(s)_____ _____ Address_____ Exposure: 1st contact___/___/___ Most recent contact: ___/___/___ Partners type: ☐sex ☐needle ☐both Frequency: ☐once ☐<5 times ☐>5 times Referred by ☐patient ☐provider ☐both Place/setting/location (club, bar, party, etc.)_____ Approx. ht____ Approx. wt____ School/work: _____ Hair color ☐Brown ☐Blond ☐Red ☐Black ☐Bald ☐Other Skin color ☐Brown ☐Black ☐White ☐Other	Hispanic ☐Yes ☐No ☐Unk ☐Ref Race (check all that apply) ☐White ☐Black ☐Asian ☐American Indian/Alaska Native ☐Pacific Islander Refused

Date partner named__/__/__ Partner age or date or birth __/__/__ Sex ☐female ☐male ☐TGF ☐TGM ☐unknown Email _____ Name_____ Phone(s)_____ AKA(s)_____ _____ Address_____ Exposure: 1st contact___/___/___ Most recent contact: ___/___/___ Partners type: ☐sex ☐needle ☐both Frequency: ☐once ☐<5 times ☐>5 times Referred by ☐patient ☐provider ☐both Place/setting/location (club, bar, party, etc.)_____ Approx ht____ Approx wt____ School/work:_____ Hair color ☐Brown ☐Blond ☐Red ☐Black ☐Bald ☐Other Skin color ☐Brown ☐Black ☐White ☐Other	Hispanic ☐Yes ☐No ☐Unk ☐Ref Race (check all that apply) ☐White ☐Black ☐Asian ☐American Indian/Alaska Native ☐Pacific Islander Refused

Date partner named__/__/__ Partner age or date or birth __/__/__ Sex ☐female ☐male ☐TGF ☐TGM ☐unknown Email _____ Name_____ Phone(s)_____ AKA(s)_____ _____ Address_____ Exposure: 1st contact___/___/___ Most recent contact: ___/___/___ Partners type: ☐sex ☐needle ☐both Frequency: ☐once ☐<5 times ☐>5 times Referred by ☐patient ☐provider ☐both Place/setting/location (club, bar, party, etc.) _____ Approx. ht____ Approx. wt.____ School/work: _____ Hair color ☐Brown ☐Blond ☐Red ☐Black ☐Bald ☐Other Skin color ☐Brown ☐Black ☐White ☐Other	Hispanic ☐Yes ☐No ☐Unk ☐Ref Race (check all that apply) ☐White ☐Black ☐Asian ☐American Indian/Alaska Native ☐Pacific Islander Refused

Date partner named__/__/__ Partner age or date or birth __/__/__ Sex ☐female ☐male ☐TGF ☐TGM ☐unknown Email _____ Name_____ Phone(s)_____ AKA(s)_____ _____ Address_____	Hispanic ☐Yes ☐No ☐Unk ☐Ref Race (check all that apply) ☐White ☐Black ☐Asian ☐American Indian/Alaska Native ☐Pacific Islander Refused

Exposure: 1st contact___/___/___ Most recent contact: ___/___/___ Partners type: ☐sex ☐needle ☐both Frequency: ☐once ☐<5 times ☐>5 times Referred by ☐patient ☐provider ☐both Place/setting/location (club, bar, party, etc.) _____ Approx. ht____ Approx. wt.____ School/work: _____ Hair color ☐Brown ☐Blond ☐Red ☐Black ☐Bald ☐Other Skin color ☐Brown ☐Black ☐White ☐Other	

Date partner named__/__/__ Partner age or date or birth __/__/__ Sex ☐female ☐male ☐TGF ☐TGM ☐unknown Email _____ Name_____ Phone(s)_____ AKA(s)_____ _____ Address_____ Exposure: 1st contact___/___/___ Most recent contact: ___/___/___ Partners type: ☐sex ☐needle ☐both Frequency: ☐once ☐<5 times ☐>5 times Referred by ☐patient ☐provider ☐both Place/setting/location (club, bar, party, etc.) _____ Approx. ht____ Approx. wt.____ School/work: _____ Hair color ☐Brown ☐Blond ☐Red ☐Black ☐Bald ☐Other Skin color ☐Brown ☐Black ☐White ☐Other	Hispanic ☐Yes ☐No ☐Unk ☐Ref Race (check all that apply) ☐White ☐Black ☐Asian ☐American Indian/Alaska Native ☐Pacific Islander Refused

Complete a copy of this page for every PARTNER interviewed. PARTNER'S NAME_____

PARTNERS EXPOSURES AND RISK (BASED ON CASE INTERVIEW OR FROM PROVIDER IF AVAILABLE)

Interviewed? ☐Y ☐N ☐R 1st call try __/__/__ Date Interviewed: __/__/___ by_____ who:_____
If no, reason_____

Tested for CT/GC ☐Yes ☐No if yes, Date ___/__/___ Tested for HIV ☐Yes ☐No if yes, Date ___/__/___

Have any of the contact's partners in the past 12 months been?	☐Female ☐male ☐TGM ☐TGF ☐R ☐U
Total number of sex partners for contact, in the past 12 months	The sum all sexual partners #_____
Had sex with an anonymous partner within past 12 months?	☐Y ☐N ☐R ☐U
Had sex with a person known to him/her to inject drugs (PWID) within the past 12 months?	☐Y ☐N ☐R ☐U
Had sex while intoxicated and/or high on drugs withing past 12 months?	☐Y ☐N ☐R ☐U
Engaged in injection (recreational) drug use within past 12 months?	☐Y ☐N ☐R ☐U If yes, name(s)_____
Engaged in non-injection (recreational) drug use within past 12 months?	☐Y ☐N ☐R ☐U If yes, name(s)_____
Had this person been incarcerated within the past 12 months?	☐Y ☐N ☐R ☐U
Have you exchanged sex for a need within the past 12 months?	☐Y ☐N ☐R ☐U
If yes, ☐money ☐drugs ☐paid bills ☐material goods ☐place to stay/sleep ☐food vehicle/transportation ☐dependent care security/protection other need(s)_____	
Had this person find partners through the internet apps, in the past 12 months?	☐Y ☐N ☐R ☐U If yes, name(s):_____
Have you ever taken PrEP for HIV prevention?	☐Y ☐N ☐R ☐U if yes, date ___/____/____
Are there challenges to continue PrEP?	☐Y ☐N ☐R ☐U If yes, what:_____

Are there challenges to start PrEP?	☐Y ☐N ☐R ☐U If yes, what:_____
Have you taken PEP for HIV prevention?	

LABORTATORY TESTS (FROM PROVIDER OR PARTNERS INTERVIEW)

Complete a copy of this page for every partner interviewed

Test 1

Test 1 Collection date: __/__/___

Specimen Type: ☐Blood ☐CSF ☐Lesion

Test Type: ☐RPR ☐VDRL ☐FTA ☐TPPA ☐Trep AB1 ☐Trep AB2

Result: ☐Positive ☐Negative ☐Equivocal ☐Titer:_____

Test 2

Test 1 Collection date: __/__/___

Specimen Type: ☐Blood ☐CSF ☐Lesion

Test Type: ☐RPR ☐VDRL ☐FTA ☐TPPA ☐Trep AB1 ☐Trep AB2

Result: ☐Positive ☐Negative ☐Equivocal Titer:____

PARTNER TREATMENT (FROM PROVIDER OR PARTNER INTERVIEW)

Treatment 1 Date ___/___/___ Drug: ☐Pen G LA ☐Doxy ☐Aqueous crystalline	Size (mg) _____	Dose _____	Frequency/duration _____
Treatment 1 Date ___/___/___ Drug: ☐Pen G LA ☐Doxy ☐Aqueous crystalline	Size (mg) _____	Dose _____	Frequency/duration _____
Treatment 1 Date ___/___/___ Drug: ☐Pen G LA ☐Doxy ☐Aqueous crystalline	Size (mg) _____	Dose _____	Frequency/duration _____

DISPOSTION	COMMENTS
☐A – Preventive Treatment ☐B – Refused Preventive Treatment ☐C – Infected, Brough to Treatment ☐D – Infected, Not Treated ☐E – Previously Treated for this Infection ☐F – Not infected ☐G – Insufficient Information to Begin Investigation ☐H – Unable to Located ☐J – Located, Refused Examination ☐K – Out of Jurisdiction ☐L – Other ☐M – Reverse Contact Link	

Case report sent to OHA on ____/____/____ ` Investigation sent to OHA on ____/____/____

Completed by _____ Date _____ Phone _____

Public Health HIV, STD, TB – STD Prevention
Contact Us
E-mail: yuritzy.a.gonzalez-pena@oha.oregon.gov
Communicable Disease Case Forms
https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/COMMUNICABLEDISEASE/REPORTINGCOMMUNICABLEDISEASE/REPORTINGFORMS/Pages/index.aspx
Phone: 503-269-0305
FAX: 971-673-0178
TTY: 711