The National Electronic Telecommunications System for Surveillance (NETSS)
CDC Implementation Plan for STD Surveillance Data

Effective as of January 2018

CDC CONTACTS:

1) Division of Health Informatics and Surveillance (DHIS) soib@cdc.gov
2) Division of STD Prevention (DSTDP) sdmb@cdc.gov

A. RECORD LAYOUT:

CDC STD surveillance data must consist of 1) the core 60-byte demographic portion established by the Division of Health Informatics and Surveillance (DHIS) at CDC, and 2) extended record data beyond the 60-byte record determined by the Division of STD Prevention (DSTDP). See **ATTACHMENT A** for the **Record Layout and additional instructions for Transmission of STD Morbidity Data.** If you have questions regarding the 60-byte record layout, contact DHIS. If there are questions on STD data in the extended record, contact DSTDP, Surveillance and Data Management Branch (SDMB).

B. CDC TRANSMISSION DEADLINES:

As required by the MMWR, STD surveillance data and verification records should be transmitted to Atlanta via Secure Data Network (SDN) on a **WEEKLY** basis. Data collected through Saturday of a given week should be transmitted to CDC by the following **Tuesday, 12:00 noon**, Atlanta time. Sites are encouraged to report on the following Monday, if possible. **Any data transmitted after the Tuesday, noon deadline will NOT be included in the MMWR published that week.** Be sure to check with the State Epi Office for their internal deadlines for data transmission.

C. STEPS FOR INITIAL TRANSMISSION:

1. The **STD surveillance reporter** should contact the state General Epi office to coordinate transmission of STD data from the STD office to the state. Issues to cover:

   a. What **diseases/event codes** will be reported through NETSS, and are there any problems with the record layout as specified by DHIS and DSTDP?

   b. **How** (CD, e-mail, handcarry) **will data be sent** to General Epi office?

   c. Will STD data be **"piggy-backed"** with General Epi data or sent to CDC separately?

   d. A policy in the event that STD data transmission is **interrupted**. Conversely, would STD office be able to transmit General Epi data if the General Epi office was unable to transmit. If STD office transmission to DHIS should be necessary, contact DHIS for more information.

   e. Establish how weekly CDC NETSS **DHIS Transmission Summary Reports** are distributed to the states, including STD Program staff and other reporting areas. Be sure to review these reports as soon as possible to facilitate weekly reconciliation of data, and contact DHIS if there are any questions. For an example of the **Transmission Summary Report**, see **ATTACHMENT B**.

2. **If a reporting area is using STD*MIS software**: In addition to contacting the state General Epi Office, the STD coordinators in the field should contact the appropriate CDC STD*MIS field representative to inform them that they are ready to begin transmission.

If a project area wants to begin transmitting during the middle of a calendar year, they will be asked by DHIS to transmit **YTD (year-to-date)** data. CDC STD*MIS field reps may be asked to provide additional technical assistance.

3. **If a reporting area is using their own software, not STD*MIS:** The STD Coordinators should contact their General Epi Office to inform them that they are ready to begin transmission of STD morbidity data.

   DHIS will ensure that the core data matches the required NETSS record layout. The extended data must match the record layout in **ATTACHMENT A.**

   ATTACHMENT C lists data elements that may need to be re-coded for NETSS transmission.

   If a project area wants to begin transmitting during the middle of a calendar year, they will be asked by DHIS to transmit **YTD (year-to-date)** data.

4. **BEFORE official transmission of STD data**, a test file should be sent from the STD office to SDMB. SDMB will check the test transmission and report the results back to the STD office. Coordination between the state STD office and SDMB is essential to ensure that all parties understand that "this is only a test".

5. **If available, YTD data should be included in the first "official" transmission of data.** Contact DHIS for questions and final approval before transmitting any YTD data. **Do NOT transmit an incomplete YTD file. A complete YTD file is a file which contains year-to-date data starting in January of the current year through the date that the transmission was prepared.** (For **example**, if data has only been entered for March 2017-September 2017, this is an **incomplete** YTD file, whereas data entered for January-September 2017 would be considered a **complete** YTD file).

   If you are unable to transmit a complete YTD file, transmit only routine weekly data until you have a complete YTD file available. The state STD office and state General Epi office should coordinate reporting of STD data during this transition phase.

D. GUIDELINES FOR ONGOING OPERATION:

Communication between the reporting areas and CDC is critical to the success of NETSS. **CDC maintains a basic list of contacts** for each reporting area which includes the CDC/DSTDP Program Coordinator, STD*MIS CDC Representative, STD Program contacts, and the DHIS NETSS contact. **Please keep CDC (DHIS and DSTDP) informed (via e-mail, phone, etc.) of any changes in NETSS-related staff, including changes to office addresses and phone numbers.**

A verification record should be included with EVERY transmission, whenever possible. NETSS transmissions to DHIS from the General Epi Office should include a complete explanation of data received, i.e., if data is a re-transmission of YTD, all data files must be labeled as such.

DHIS is responsible for maintaining the core (60-byte) record. DHIS will receive the data, check the core portion for errors, and notify the state NETSS reporter of the number of records received and errors to be corrected (weekly **DHIS Transmission Summary Reports** from CDC). **STD field personnel should make sure they receive a copy of this report from the General Epi Office in order to receive notice of their errors.** Currently, the Transmission Summary Report (See Attachment B) lists errors by year, week, site code and caseid.

DSTDP is responsible for maintaining program specific (extended record) data beyond the 60-byte core record. DHIS will assemble both core records and extended records for STD data and make them available to DSTDP on a weekly basis. The DSTDP Data Management Unit will be responsible for checking the extended record data and communicating with the state STD office regarding corrections. DSTDP will be responsible for contacting the state.

Whenever NETSS **unique identifiers** (STATE, YEAR, SITE, and CASEID) in previously-transmitted data need to be corrected or updated, a DELETION record should be sent to remove the previously-transmitted data from the CDC database. A new record should then be sent to DHIS to add the corrected or updated data to the CDC database.

If the data being corrected is **not a unique identifier**, then you can simply modify the record and re-transmit it, without deleting the record.

E. FOR A COPY OF THIS IMPLEMENTATION PLAN:

Contact DSTDP staff via e-mail (sdmb@cdc.gov) for the most recent version of this plan either as hardcopy or as an electronic document. Your suggestions or comments for improving and clarifying this implementation plan are welcome!

ATTACHMENT A

THE NATIONAL ELECTRONIC TELECOMMUNICATIONS SYSTEM FOR SURVEILLANCE (NETSS) and STD SURVEILLANCE DATA: RECORD LAYOUT AND INSTRUCTIONS

The National Electronic Telecommunications System for Surveillance (NETSS)
And STD Surveillance Data: Record Layout and Instructions

CDC Contacts for STD-related NETSS Questions

DSTDP staff: sdmb@cdc.gov (e-mail)

Types of NETSS Records:

There are three types of records that can be transmitted via NETSS: (1) CASE record; (2) DELETION record; and, (3) VERIFICATION record.

1. **CASE** Record:
   A separate record is submitted for each case reported (line-listed data).
   [Column 1 = M for MMWR report].
2. **DELETION** Record:
   This record is used to delete any previously-transmitted records with incorrect unique identifiers (STATE, YEAR, SITE and CASEID) or to delete records that should no longer be reported.
   [Column 1 = D for Deletion].
3. **VERIFICATION** Record:
   A single record is used for each disease to report the total number of cases that have been transmitted year-to-date. This record is used to assist in reconciling any differences between the number of cases in the CDC database and the number of cases in the State database.
   [Column 1 = V for Verification].

* **NOTE:** To UPDATE a previously sent record, you must re-transmit the record and the CDC system will overwrite the old record, based on the unique identifiers. However, if the error is one of the unique identifiers, then you must first send a deletion record and then re-transmit the corrected record.

Content of NETSS Record:

CORE DATA:

The first 60 bytes of any of the 3 types of NETSS records (referred to as CORE data) are transmitted for all notifiable diseases. The accompanying NETSS record layouts indicate which data items within the CORE data are required by CDC, i.e., a NETSS record will not be accepted at CDC unless those data are on the record. Any data beyond 60 bytes (referred to as PROGRAM or EXTENDED data) are program-specific data, i.e., the data are used only by the specific programs and not by the MMWR staff for any weekly MMWR tables.

PROGRAM/EXTENDED DATA:

In the STD NETSS EXTENDED CASE record, it is important to transmit **information about where the case was identified**, i.e., the facility type (information source) on the Interview Record currently being implemented. This information will allow DSTDP staff in Atlanta to examine the number of cases from STD clinics versus all other sources.

It is also important to transmit **information about how each case was detected**, i.e., the method of case detection from the Interview Record currently being implemented. Not all reporting areas will have this information easily linked to their morbidity data. However, those areas that do have that information linked with their morbidity data are asked to transmit that information as part of the STD NETSS EXTENDED CASE record.

In addition to facility type and method of case detection, the STD NETSS EXTENDED CASE record can include the Zip Code of residence for the case IF that information is available and easily linked with the morbidity data.

For congenital syphilis case records, the STD NETSS EXTENDED CASE record should include data from the Congenital Syphilis (CS) Case Investigation and Report form (the 126 form) that was not included in the CORE

data. A specific format for transmission of the 126 data is provided on the accompanying STD NETSS record layouts.

Transmission of NETSS Data

STD surveillance data should be transmitted to Atlanta via NETSS **every week**. Specifically, data collected through Saturday of a given week should be transmitted to CDC by the following Tuesday, 12:00 Noon, Atlanta time. Sites are encouraged to report to their General Epi Office on the following Monday if possible. **Any data transmitted after the Tuesday Noon deadline will NOT be included in the MMWR published that week.**

Whenever previously-transmitted STD surveillance data needs to be corrected or updated, the following rules apply. (1) **If the fields that need correcting or updating are STATE/YEAR/CASEID/SITE**, a DELETION record should be sent to remove the previously-transmitted data from the CDC database. A new record should then be sent to add the correct data to the CDC database. (2) **If the field(s) that need correcting or updating are any other than those listed above,** simply transmit the record with the updated information to CDC. The corrected/updated record should have STATE/YEAR/CASEID/SITE fields that match the previously-transmitted record. This new corrected/updated record will replace the previously-transmitted record in the CDC database.

Specific STDs Reported Via NETSS:

1. **SYPHILIS**
   a. Submit CASE record
   b. Disease Codes:
      10311 = Primary syphilis
      10312 = Secondary syphilis
      10313 = Syphilis, early non-primary non-secondary
      10316 = Congenital syphilis
      10320 = Syphilis, unknown duration or late
2. **CHANCROID**
   a. Submit CASE record
   b. Disease Code: 10273
3. **CHLAMYDIA**
   a. Submit CASE record
   b. Disease Code: 10274
4. **GONORRHEA**
   a. Submit CASE record
   b. Disease Code: 10280

COUNTY of Residence

Cases should be counted for morbidity purposes by the patient's usual place of residence (state or county) and not by place of occurrence or diagnosis. When a case is diagnosed and the patient is a resident of another state, the state in which the case is diagnosed should forward the case report to the state of usual residence for inclusion in the latter state's morbidity system. When usual place of residence is not clear or when cases are diagnosed among merchant seamen or foreign nationals, the cases should be counted in the place of diagnosis.

National Electronic Telecommunications System for Surveillance (NETSS)
REVISED RECORD LAYOUT FOR TRANSMISSION OF STD MORBIDITY DATA
(Chancroid, Chlamydia, Gonorrhea, Syphilis)
(Effective as of January 2018)

Data Element Name	*N/ M	Data Element Definition	Columns	Data Element "legal" Values	Data Element "legal" value definition	Required/ Optional+
CODE KEY *N=New (2018); M=Modified (2018) +**Req**=**Req**uired; **Opt**=Optional; CT=Chlamydia; G=Gonorrhea; S=Syphilis; CH=Chancroid						
RECORD TYPE		Record type will determine how the record is handled when it arrives at CDC.	1	M=MMWR report		**Req** CT, G, S, CH
UPDATE		Currently not implemented (pad with a 9).	2	9		**Req** CT, G, S, CH
STATE		State reporting case information & jurisdiction of case (based on patient residence).	3-4	Standard 2-digit State FIPS code.	Reporting state is defined using CSTE:CDC criteria available at: https://wwwn.cdc.gov/nndss/document/11-SI-04.pdf	**Req** CT, G, S, CH
YEAR		*MMWR* Year for which case information was reported to CDC. Derived from *MMWR* week.	5-6	2-digit year (##)	Based on *MMWR* week assignment.	**Req** CT, G, S, CH
CASE REPORT ID		Unique Case Report ID (numeric) assigned by the state.	7-12	6-digit numeric	Non-identifying ID for case report, NOT case-patient. Represents incident case report. Assigned by state, in combination with other variables (e.g. Reporting state +/- associated date) will represent a unique case in national data base.	**Req** CT, G, S, CH
SITE CODE		Location code assigned by the state to indicate where report originated and who has responsibility for maintaining the record.	13-15	S01=State epidemiologist S02=State STD Program S03=State Chronic Disease Program S04-S99=Other state offices R01-R99=Regional or district offices 001-999=County health depts (FIPS codes) L01-L99=Laboratories within state CD1=Historical records (prior to new format) CD2=Entered at CDC (based on phone reports) #<##>=Entered in STD*MIS application; 2-digit code represents the state specific installation of STD*MIS	Project areas should NOT re-use SITE codes over time. If a new site is added, please assign a new, unique SITE ID. If a site is no longer reporting to your surveillance system, RETIRE the site ID - do not re-use. Project areas should also maintain up-to-date lists of SITE IDs with information describing the site characteristics (e.g. location, contact person and contact information), so the SITE IDs and their meaning can be shared as needed.	**Req** CT, G, S, CH
WEEK	M	*MMWR* Week on Surveillance Calendar.	16-17	01 through 53, dependent upon Surveillance Calendar	*MMWR* Week should be assigned using the date in the variable "Event Date" and should be based on the following hierarchy: • Date of disease onset • Date of diagnosis (proxy: Date of laboratory specimen collection) • Date of laboratory result • Date of first report to public (community) health system • State or *MMWR* report date	**Req** CT, G, S, CH

Data Element Name	*N/ M	Data Element Definition	Columns	Data Element "legal" Values	Data Element "legal" value definition	Required/ Optional+
CODE KEY *N=New (2018); M=Modified (2018) +**Req**=**Req**uired; **Opt**=Optional; CT=Chlamydia; G=Gonorrhea; S=Syphilis; CH=Chancroid						
EVENT or DIAGNOSIS	M	STD or associated syndrome (health event) for which the case-patient has been diagnosed (regardless of case status per CSTE/CDC surveillance case definition).	18-22	10273=Chancroid	Health event = "Chancroid" per CSTE/CDC surveillance case definition (regardless of case classification status [confirmed or probable])	**Req** CT, G, S, CH
				10274=*Chlamydia trachomatis* infection	Health event = "*Chlamydia trachomatis* infection" per CSTE/CDC surveillance case definition	
				10276=RETIRED	NOTE: Granuloma inguinale (GI) code "10276" is retired (no longer used for case reporting).	
				10280=Gonorrhea	Health event = "Gonorrhea" per CSTE/CDC surveillance case definition (regardless of case classification status [confirmed or probable]).	
				10306=RETIRED	NOTE: Lymphogranuloma venereum (LGV) code "10306" is retired (no longer used for case reporting).	
				10307=RETIRED	NOTE: Non-Gonococcal Urethritis (NGU) code "10307" is retired (no longer used for case reporting).	
				10308=RETIRED	NOTE: Mucopurulent Cervicitis (MPC) code "10308" is retired (no longer used for case reporting).	
				10309=RETIRED	NOTE: Pelvic Inflammatory Disease (PID) [unknown etiology] code "10309" is retired (no longer used for case reporting).	
				10311=Syphilis, primary	Health event = "Syphilis, primary" per CSTE/CDC surveillance case definition (regardless of case classification status [confirmed, probable, or suspect]).	
				10312=Syphilis, secondary	Health event = "Syphilis, secondary" per CSTE/CDC surveillance case definition (regardless of case classification status [confirmed, probable, or suspect]).	
				10313=Syphilis, early non-primary non-secondary	Health event = "Syphilis, early non-primary non-secondary" per CSTE/CDC surveillance case definition (regardless of case classification status [confirmed or probable]).	
				10314=RETIRED	NOTE: Syphilis, late latent code 10314 is retired (no longer used for case reporting).	
				10315=RETIRED	NOTE “Syphilis, unknown latent” code "10315" is retired (no longer used for case reporting).	
				10317=RETIRED	NOTE: Neurosyphilis code "10317" is retired (no longer used for case reporting).	
				10318=RETIRED	NOTE “Late Syphilis with clinical manifestations other than neurosyphilis” code "10318" is retired (no longer used for case reporting).	

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EVENT or DIAGNOSIS (cont'd)				10319=RETIRED	NOTE: Syphilis, late with clinical manifestations (including late benign syphilis and cardiovascular syphilis code 10319 is retired (no longer used for case reporting).	
				10320= Syphilis, unknown duration or late	Health event = "Syphilis, unknown duration or late" per CSTE/CDC surveillance case definition (regardless of case classification status [confirmed or probable]).	
COUNT		Represents # of cases reported in this 'record'; supports aggregate- (when >1) or case-specific (when=1) reporting.	23-27	#####	Number of case reports represented in this record. Default = 00001 for case-specific records where a single case is represented by data record.	**Req** CT, G, S, CH
COUNTY		Standard FIPS code for county of case-patient's residence in reporting state.	28-30	3-digit county FIPS *(999=Unknown)*	In combination with State FIPS, represents a unique US county ID.	**Req** CT, G, S, CH
DATE OF BIRTH		Date of birth of case-patient in YYYYMMDD format.	31-38	YYYYMMDD (99999999=Unknown)		**Req** CT, G, S, CH
AGE		Age of case-patient at time of initial exam or specimen collection for case report "condition".	39-41	### (999=Unknown)	Note: Must report "AGETYPE" value to determine time units associated with "AGE".	**Req** CT, G, S, CH
AGETYPE		Indicates the units (years, months, etc.) for the AGE field.	42	0=0-120 years 1=0-11 Months 2=0-52 Weeks 3=0-28 Days 9=Age Unknown (AGE field should be 999)		**Req** CT, G, S, CH
SEX		Current sex of patient	43	1=Male 2=Female 9=Unknown		**Req** CT, G, S, CH
RACE		Race	44	9=(Default)	This variable should default to 9. It has been superseded by the individual RACE variables located in columns 98-105.	**Req** CT, G, S, CH
HISPANIC		Indicator for Hispanic ethnicity.	45	9=(Default)	This variable should default to 9. It has been superseded by the HISPANIC/LATINO variable located in column 106.	**Req** CT, G, S, CH
EVENT DATE	M	Date of disease in YYMMDD format.	46-51	YYMMDD (999999=Unknown)	Date should most closely approximate the date of disease onset (incidence) and should be based on the following hierarchy: • Date of disease onset • Date of diagnosis (proxy: Date of laboratory specimen collection) • Date of laboratory result • Date of first report to public (community) health system • State or *MMWR* report date Note: When date of diagnosis or date of laboratory result are not readily available, but date of laboratory specimen collection date is available, date of laboratory specimen collection should be considered a proxy for date of diagnosis and should be used to assign "event date."	**Req** CT, G, S, CH

Data Element Name	*N/ M	Data Element Definition	Columns	Data Element "legal" Values	Data Element "legal" value definition	Required/ Optional+
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DATETYPE		Describes the type of date provided in EVENT DATE.	52	1=Onset Date 2=Date of diagnosis (Proxy: Date of laboratory specimen collection) 3=Date of laboratory result 4=Date of first report to community health system 5=State/*MMWR* report date 9=Unknown	Note: When date of diagnosis or date of laboratory result are not readily available, but date of laboratory specimen collection date is available, date of laboratory specimen collection should be considered a proxy for date of diagnosis and should be used to assign "event date."	**Req** CT, G, S, CH
CASE STATUS		Status of the case/event as suspect, probable, or confirmed.	53	1=Confirmed case 2=Probable case 3=Suspect case 9=Unknown case status	Note: Please review CSTE/CDC case definitions for information on case classification status. (https://wwwn.cdc.gov/nndss/case-definitions.html)	**Req** CT, G, S, CH
IMPORTED		Indicates if the case was imported into the state or the U.S.	54	9=(Default)	This variable should default to 9. It has been superseded by the STD IMPORT variable located in column 113.	**Req** CT, G, S, CH
OUTBREAK		Indicates whether the case was associated with an outbreak.	55	1=Yes 2=No 9=Unknown		**Req** CT, G, S, CH
FUTURE		Reserved for future use (pad with 99999).	56-60	99999		**Req** CT, G, S, CH
INFOSRCE - Facility Type (STD dx, rx)		Setting or health care facility where a person first received diagnosis, treatment or testing for STD or associated syndrome reported in this case report (i.e., facility type of STD diagnosis, facility type where person was tested for STD).	61-62	01=HIV Counseling and Testing Site	A public clinic whose primary mission is to provide counseling and HIV testing services.	**Req** CT, G, S, CH
				02=STD clinic (Represents PUBLIC to match old reporting forms.)	A clinic whose primary mission is to provide diagnosis, treatment, counseling, and sex partner notification for sexually transmitted diseases.	
				03=Drug Treatment	A residential or outpatient clinic whose primary mission is to provide treatment for an individual's drug, alcohol, and other substance addiction.	
				04=Family Planning	A clinic whose primary mission is to provide contraceptive and reproductive health care for the prevention and achievement of pregnancy. Such sites receive federal and/or state family planning funds and are situated in state or county health departments or are community-based organizations (may include Title X and non-Title X funded facilities, including Planned Parenthood clinics).	
				06=Tuberculosis clinic	A clinic for the screening, diagnosis, treatment, and follow-up o findividuals with tuberculosis and contacts of individuals positive for TB.	
				07=Other Health Department Clinic	A public clinic administered by a local or state health department that can not be classified in one of the other defined disease- or medical service-specific facility types.	
				08=Private Physician/HMO	A non-publicly-funded group of health care providers or an individual health care	

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INFOSRCE - Facility Type (STD dx, rx) (cont'd)					provider who provides medical care (e.g., general/family/internal medicine practitioners, pediatricians).	
				10= Hospital - Emergency Room; Urgent Care facility	A department in a hospital or clinic staffed and equipped to provide emergency care to persons requiring immediate medical treatment. (includes Urgent Care).	
				11=Correctional facility	A prison, jail, detention center, or other correctional facility where persons are incarcerated or supervised by the criminal justice system.	
				12=Laboratory	Facility providing the clinical diagnostic testing of biological or environmental specimens using a variety of test methods and reporting of results.	
				13=Blood Bank	Facility where blood donations are taken, blood is screened and processed to ensure viability, and stored until needed.	
				14=Labor and delivery	A facility providing health care services to women during labor and delivery through birth of the infant.	
				15=Prenatal	A clinic whose primary mission is to provide health care and education to pregnant women (from time of diagnosis of pregnancy to the time of labor and delivery).	
				16=National Job Training Program	A residential,educational, and job training program for at-risk youth aged 16 to 24 years. National Job Training Program is a public-private partnership administered by the U.S. Department of Labor and the Employment and Training Administration.	
				17=School-based Clinic	A clinic located in or affiliated with a middle school, junior high school, senior high school, or other type of school providing education at or below 12th grade that provides medical care and health education to students.	
				18=Mental Health Provider	Facility or provider providing inpatient or outpatient mental health services.	
				29=Hospital – Other	A multidisciplinary public or private facility that provides non-emergency inpatient or outpatient medical services. Includes specialty clinics within a hospital (Excludes care sites that provide emergency or urgent care and obstetric or labor and delivery services.)	
				66=Indian Health Service	A medical care facility funded by the Indian Health Service.	
				77=Military	A facility operated by the U.S. military whose primary mission is to provide health care.	

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				88=Other	A clinic that can not be categorized in any of the other defined facility types.	
				99=Unknown (if data not available)	Facility type not available.	
Method of Case Detection		How did the case patient first come to the attention of the health department for this condition?	63-64	20=Screening	An asymptomatic patient was identified through screening (routine testing of populations who are asymptomatic in order to identify those with disease). Examples of screening programs include health department outreach to high-risk populations (e.g., commercial sex-workers), HIV care clinics, family planning, blood donation, corrections-based, and prenatal. This includes STD and other health department clinic visits by a client who tests positive for a condition with which they were unaware (e.g., asymptomatic walk-ins) of before being seen at the clinic.	**Req** S **Opt** CT, G, CH
				21=Self-referred	Refers to patient who sought health services because of signs of an STD and was subsequently tested for the disease being reported. This includes symptomatic STD clinic testing.	
				22=Patient Referred Partner	Patient referred by another infected person. This may be a named or unnamed partner. No health department involvement was necessary for this referral.	
				23=Health Department referred partner	This patient is a named partner of a known case. Patient identified through DIS, or other health department personnel, activity following an interview of another known case. The health department was involved in the referral of this individual (e.g., the DIS contacted, called, visited, sent letter, etc., the patient to inform them of their need to be tested).	
				24=Cluster related	Patient was originally identified as a Social Contact (Suspect) or Associate. Cluster brought to the attention of the program as a result of a DIS interview.	
				88=Other	In the event that values 20-24 do not apply, please select this value.	
ZIP		5-digit Zip code of residence of the case patient.	65-69	#####; (99999=Unknown, if data not available)		**Req** CT, G, S, CH
CITY (DISCONTINUED)		Previously collected CITY data.	70-73	9999=(Default)	This variable should be set to 9999. It is no longer being collected by DSTDP.	
PID (DISCONTINUED)		Previously collected PID data.	74	9=(Default)	This variable should be set to 9. It is no longer being collected by DSTDP.	
Pregnant - initial exam		Was the case patient pregnant at time of initial exam for the condition reported in this case report?	75	1=Yes 2=No 9=Unknown		**Req** S Opt CT, G, CH

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ORIGIN (DISCONTINUED)		Previously collected ORIGIN-Source of morbidity report.	76	9=(Default)	This variable should be set to 9. It is no longer being collected by DSTDP.	
DX_DATE (DISCONTINUED)		Previously collected date of diagnosis.	77-84	99999999=(Default)	This variable should be set to 99999999. It is no longer being collected by DSTDP.	
Specimen source		Anatomic site or specimen type from which positive lab specimen was collected.	85-86	01=Cervix/Endocervix 02=Lesion-Genital 03=Lesion-Extra Genital 04=Lymph Node Aspirate 05=Oropharynx 06=Ophthalmia/Conjunctiva 07=Other 08=Other Aspirate 09=Rectum 10=Urethra 11=Urine 12=Vagina 13=Blood/Serum 14=Cerebrospinal fluid (CSF) 88=Not Applicable 99=Unknown		**Req** CT, G **Opt** S, CH
Date of laboratory specimen collection		Date of collection of initial laboratory specimen used for diagnosis of health event reported in this case report.	87-94	YYYYMMDD format (99999999=Unknown)	PREFERRED date for assignment of *MMWR* week. First date in hierarchy of date types associated with case report/event.	**Req** CT, G, S, CH
Neurological involvement?	M	If event = some stage of syphilis, does the patient have neurologic involvement based on current case definition?	95	9=(Default)	This variable should be set to 9. It has been superseded by the neurologic manifestations variable located in column 192.	**Req** S
INTERVIEW (DISCONTINUED)		Previously collected interview case status.	96	9=(Default)	This variable should be set to 9. It is no longer being collected by DSTDP.	
PARTNER (DISCONTINUED)		Previously collected sex of sex partners.	97	9=(Default)	This variable should be set to 9. It has been superseded by the sex partner data located in columns 147-148.	
American Indian/ Alaska native?		Case patient reported Am Indian/Alaska Native (AI/AN) race	98	Y = Yes U=(Default)	Y = Yes, case-patient reports AI/AN race; Otherwise pad with a "U".	**Req** CT, G, S, CH
Asian?		Case patient reported Asian race	99	Y = Yes U=(Default)	Y = Yes, case-patient reports Asian race; Otherwise pad with a "U".	**Req** CT, G, S, CH
Black/African American?		Case patient reported Black/African American (B) race	100	Y = Yes U=(Default)	Y = Yes, case-patient reports Black race; Otherwise pad with a "U".	**Req** CT, G, S, CH
Native Hawaiian/ Pacific Islander?		Case patient reported Native Hawaiian/Pacific Island (NH/PI) race	101	Y = Yes U=(Default)	Y = Yes, case-patient reports NH/PI race; Otherwise pad with a "U".	**Req** CT, G, S, CH
White?		Case patient reported White (W) race	102	Y = Yes U=(Default)	Y = Yes, case-patient reports White race; Otherwise pad with a "U".	**Req** CT, G, S, CH
Other race?		Case patient reported some other race (not AI/NA, Asian, Black, NH/PI, White)	103	Y = Yes U=(Default)	Y = Yes, case-patient reports some other race (not AI/AN, Asian, Black, NH/PI, or White); Otherwise pad with a "U".	**Req** CT, G, S, CH

Data Element Name	*N/ M	Data Element Definition	Columns	Data Element "legal" Values	Data Element "legal" value definition	Required/ Optional+
CODE KEY *N=New (2018); M=Modified (2018) +**Req**=**Req**uired; **Opt**=Optional; CT=Chlamydia; G=Gonorrhea; S=Syphilis; CH=Chancroid						
Refused to report race		Case patient refused to report race	104	Y = Yes U=(Default)	Y = Yes, case-patient refused to report race; Otherwise pad with a "U".	**Req** CT, G, S, CH
Unknown race		Case patient could not answer this question for any reason	105	Y = Yes U=(Default)	Y = Yes, case-patient could not provide information regarding their race; Otherwise pad with a "U".	**Req** CT, G, S, CH
Hispanic/Latino?		Indicator for case-patient's Hispanic/Latino ethnicity.	106	Y=Yes	Case-patient reports Hispanic or Latino ethnicity.	**Req** CT, G, S, CH
				N=No	Case-patient does NOT report Hispanic or Latino ethnicity.	
				U=Unknown	Case-patient's ethnicity information is not known.	
				R = Refused to answer	Case-patient refused to respond to questions regarding ethnicity.	
Census tract of case-patient residence		Census tract where the address is located is a unique identifier associated with a small statistical subdivision of a county. Census tract data allows a user to find population and housing statistics about a specific part of an urban area. A single community may be composed of several census tracts.	107-112	6-character length alphanumeric		**Opt** CT, G, S, CH
STD IMPORT		Was case imported? Was disease acquired elsewhere? Indicates probable location of disease acquisition relative to reporting state.	113	N - Not an imported case	Health event for this case report was acquired in the reporting state or intrastate jurisdiction that was responsible for case management.	**Opt** CT, G, S, CH
				C – Yes, imported from another country	Health event for this case report was acquired outside the US	
				S - Yes, imported from another state	Health event for this case report was acquired in the US, but not in the reporting state	
				J - Yes, imported from another county/ jurisdiction in the state	Health event for this case report was acquired in another county/jurisdiction in the state. Implies intrastate cross-jurisdictional activity may have been initiated for STD control.	
				D - Yes, imported but not able to determine source state and/or country	Health event for this case report was imported from outside the reporting state, but there is insufficient information to determine if the disease was acquired within or outside the US	
				U - Unknown	Insufficient information is available to determine where disease acquisition occurred.	
Date of initial health exam associated with case report "health event"		Date of **earliest** healthcare encounter/visit /exam associated with this event/case report. May equate with date of exam or date of diagnosis.	114-121	YYYYMMDD format (99999999=Unknown) (99999999=N/A)		**Req** CT, G, S, CH if date of laboratory specimen collection is not reported

Data Element Name	*N/ M	Data Element Definition	Columns	Data Element "legal" Values	Data Element "legal" value definition	Required/ Optional+
CODE KEY *N=New (2018); M=Modified (2018) +**Req**=**Req**uired; **Opt**=Optional; CT=Chlamydia; G=Gonorrhea; S=Syphilis; CH=Chancroid						
Date of first report of case/event to public health system		Date of first report of case to local or state health department (first tier of public health system in reporting jurisdiction; may equate to city, county, region, or state public health system level).	122-129	YYYYMMDD format (99999999=Unknown) (99999999=N/A)		**Req** CT, G, S, CH if date of laboratory specimen collection AND date of initial health exam associated with the case report "health event" are not reported
Treatment date		Date treatment initiated for the condition that is the subject of this case report.	130-137	YYYYMMDD format (99999999=Unknown)		**Req** S **Opt** CT, G, CH
Date case report initially sent from reporting jurisdiction to CDC		INITIAL date case report was sent from reporting jurisdiction to CDC. Generated by the reporting jurisdiction at the time of report to CDC. Can be generated by the information system.	138-145	YYYYMMDD format (99999999=Unknown)		**Opt** CT, G, S,CH
HIV status?		Documented or self-reported HIV status at the time of event.	146	P = HIV positive N = HIV negative E = Equivocal HIV test result U = Unknown R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
Had sex with a male within past 12 months?			147	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
Had sex with a female within past 12 months?			148	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
Had sex with an anonymous partner within past 12 months?			149	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
Had sex with a person known to him/her to be an IDU within past 12 months?			150	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
Had sex while intoxicated and/or high on drugs within past 12 months?			151	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
Exchanged drugs/money for sex within past 12 months?			152	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH

Data Element Name	*N/ M	Data Element Definition	Columns	Data Element "legal" Values	Data Element "legal" value definition	Required/ Optional+
CODE KEY *N=New (2018); M=Modified (2018) +**Req**=**Req**uired; **Opt**=Optional; CT=Chlamydia; G=Gonorrhea; S=Syphilis; CH=Chancroid						
Had sex with a person who is known to her to be an MSM within past 12 months?		NOTE: For women only.	153	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
Engaged in injection drug use within past 12 months?			154	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
During the past 12 months, which of the following injection or non-injection drugs have been used?						
Crack		A potent, relatively cheap, addictive variety of cocaine; often a rock, usually smoked through a crack-pipe (synonyms: rock, rock cocaine).	155	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
Cocaine		A stimulant narcotic in the form of a white powder that users generally self-administer by insufflation through the nose (synonyms: coke, snow, blow).	156	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
Heroin		An addictive, narcotic drug derived from opium (synonyms: horse, junk, smack).	157	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
Methamphetamines		A highly addictive phenethylamine stimulant drug (synonyms: ice, crystal, meth).	158	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
Nitrates/Poppers		Any one of various alkyl nitrites (particularly amyl nitrite, butyl nitrite and isobutyl nitrite) taken for recreational purposes through direct inhalation.	159	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
Erectile dysfunction (ED) medications		Any one of several drugs available by prescription (e.g.Viagra) used to treat erectile dysfunction.	160	Y = Yes N = No R = Refused to answer D = Did not ask	Note: Over-the-Counter (OTC) herbal medicines or remedies to treat ED should NOT be considered 'eligible' ED drugs for the purposes of this question.	**Req** S **Opt** CT, G, CH
Other drug(s) used?		Other drug = type of injection or non-injection drug used for recreational purposes that is not listed above.	161	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
No drug use reported			162	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
Been incarcerated within past 12 months?			163	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
History of ever having an STD prior		Does the patient have a history of ever having had an STD prior to the	164	Y=Yes, patient has a history of STD N=No, patient has never		**Req** S **Opt** CT, G, CH

Data Element Name	*N/ M	Data Element Definition	Columns	Data Element "legal" Values	Data Element "legal" value definition	Required/ Optional+
CODE KEY *N=New (2018); M=Modified (2018) +**Req**=**Req**uired; **Opt**=Optional; CT=Chlamydia; G=Gonorrhea; S=Syphilis; CH=Chancroid						
to this STD diagnosis?		condition reported in this case report?		had a prior STD U=Unknown if patient has had a prior STD R = Patient refused to answer any questions regarding prior STD history		
Have you met sex partners through the Internet in the last 12 months?		Did the patient use an online computer site to exchange messages by typing them onscreen to engage in conversation with other visitors to the site for the purpose of having sex?	165	Y = Yes N = No R = Refused to answer D = Did not ask		**Req** S **Opt** CT, G, CH
Total number of sex partners last 12 months?		Total number of claimed sex partners that the case patient has had in the last 12 months. Total partners equal the sum of all male, female, and transgender partners during the last 12 months. Those marked unknown or refused are excluded from the total.	166-168	### 888=Patient refused to answer questions regarding number of sex partners 999=Unknown number of sex partners in last 12 months		**Req** S **Opt** CT, G, CH
Clinician-observed lesion(s) indicative of syphilis were identified at which of the following anatomic site(s)? (Mark all that apply.)		If condition = any stage of syphilis, report anatomic site(s) of clinician-observed lesion(s) (e.g., chancre, rash, condyloma lata) at time of initial exam or specimen collection. Mark all that apply.				
A=Anus/Rectum		One or more lesion(s) indicative of syphilis were present in the anus or rectum.	169	Y= Yes U=(Default)	Variable value is Y, dependent upon whether a lesion compatible with syphilis was observed at this anatomic site; Otherwise pad with a "U".	**Req** S **Opt** CH
B=Penis		One or more lesion(s) indicative of syphilis were present on the penis.	170	Y= Yes U=(Default)	Variable value is Y, dependent upon whether a lesion compatible with syphilis was observed at this anatomic site; Otherwise pad with a "U".	**Req** S **Opt** CH
C=Scrotum		One or more lesion(s) indicative of syphilis were present on the scrotum.	171	Y= Yes U=(Default)	Variable value is Y, dependent upon whether a lesion compatible with syphilis was observed at this anatomic site; Otherwise pad with a "U".	**Req** S **Opt** CH
D=Vagina		One or more lesion(s) indicative of syphilis were present in the vagina.	172	Y= Yes U=(Default)	Variable value is Y, dependent upon whether a lesion compatible with syphilis was observed at this anatomic site; Otherwise pad with a "U".	**Req** S **Opt** CH
E=Cervix		One or more lesion(s) indicative of syphilis were present on the cervix.	173	Y= Yes U=(Default)	Variable value is Y, dependent upon whether a lesion compatible with syphilis was observed at this anatomic site; Otherwise pad with a "U".	**Req** S **Opt** CH
F=Nasopharynx		One or more lesion(s) indicative of syphilis were present in the nasopharynx.	174	Y= Yes U=(Default)	Variable value is Y, dependent upon whether a lesion compatible with syphilis was observed at this anatomic site; Otherwise pad with a "U".	**Req** S **Opt** CH
G=Mouth/Oral cavity		One or more lesion(s) indicative of syphilis were present in the mouth or oral cavity.	175	Y= Yes U=(Default)	Variable value is Y, dependent upon whether a lesion compatible with syphilis	**Req** S **Opt** CH

Data Element Name	*N/ M	Data Element Definition	Columns	Data Element "legal" Values	Data Element "legal" value definition	Required/ Optional+
CODE KEY *N=New (2018); M=Modified (2018) +**Req**=**Req**uired; **Opt**=Optional; CT=Chlamydia; G=Gonorrhea; S=Syphilis; CH=Chancroid						
					was observed at this anatomic site; Otherwise pad with a "U".	
H=Eye/conjunctiva		One or more lesion(s) indicative of syphilis were present on the eye or conjunctiva.	176	Y= Yes U=(Default)	Variable value is Y, dependent upon whether a lesion compatible with syphilis was observed at this anatomic site; Otherwise pad with a "U".	**Req** S **Opt** CH
I=Head		One or more lesion(s) indicative of syphilis were present on the head.	177	Y= Yes U=(Default)	Variable value is Y, dependent upon whether a lesion compatible with syphilis was observed at this anatomic site; Otherwise pad with a "U".	**Req** S **Opt** CH
J=Torso		One or more lesion(s) indicative of syphilis were present on the torso.	178	Y= Yes U=(Default)	Variable value is Y, dependent upon whether a lesion compatible with syphilis was observed at this anatomic site; Otherwise pad with a "U".	**Req** S **Opt** CH
K=Extremities (Arms, legs, feet, hands)		One or more lesion(s) indicative of syphilis were present on the extremities (arms, legs, feet, hands).	179	Y= Yes U=(Default)	Variable value is Y, dependent upon whether a lesion compatible with syphilis was observed at this anatomic site; Otherwise pad with a "U".	**Req** S **Opt** CH
N= No lesion noted		Patient was evaluated but no lesion(s) indicative of syphilis were observed.	180	Y= Yes U=(Default)	Variable value is Y, dependent upon whether a lesion compatible with syphilis was observed at this anatomic site; Otherwise pad with a "U".	**Req** S **Opt** CH
O=Other anatomic site not represented in other defined anatomic sites		One or more lesion(s) indicative of syphilis were present in some other anatomic site not represented in the defined anatomic sites.	181	Y= Yes U=(Default)	Variable value is Y, dependent upon whether a lesion compatible with syphilis was observed at this anatomic site; Otherwise pad with a "U".	**Req** S **Opt** CH
U=Unknown		Anatomic site of lesion information is not available for whatever reason, e.g. patient not evaluated or information is not available for data entry.	182	Y= Yes U=(Default)	Variable value is Y, dependent upon whether a lesion compatible with syphilis was observed at this anatomic site; Otherwise pad with a "U".	**Req** S **Opt** CH
Type of non-treponemal serologic test for syphilis Type of non-treponemal serologic test for syphilis (cont'd)		What type of non-treponemal serologic test for syphilis was performed on specimen collected to support case patient's diagnosis of syphilis?	183	1= Rapid Plasma Reagin (RPR) 2= Venereal Disease Research Laboratory test (VDRL) (serology) 3=VDRL test of cerebrospinal fluid (CSF) 9= Unknown test type		**Req** S
Quantitative syphilis test result		If the test performed provides a quantifiable result, provide quantitative result (e.g. if RPR is positive, provide titer, e.g. 1:64)	184-189	###### (see Ex. A) <##### (see Ex. B) >##### (see Ex. B) NR= nonreactive WR= weakly reactive 999999= unknown	Example A: If titer is 1:64, enter 64; if titer is 1:1024, enter 1024. Example B: Valid entries: <titer value or >titer value. For example, <64 or >16384. All entries should be left justified (no preceding or trailing zeroes).	**Req** S
NETSS Version	M	What version of the NETSS record layout are you providing?	190-191	05=Version 5		**Req** CT, G, S, CH
Neurologic manifestations	M	If event = some stage of syphilis, does the patient have neurologic manifestations of syphilis?	192	1 = Yes, Verified 2 = Yes, Likely 3 = Yes, Possible 4 = No 9 = Unknown		**Req** S

Data Element Name	*N/ M	Data Element Definition	Columns	Data Element "legal" Values	Data Element "legal" value definition	Required/ Optional+
CODE KEY *N=New (2018); M=Modified (2018) +**Req**=**Req**uired; **Opt**=Optional; CT=Chlamydia; G=Gonorrhea; S=Syphilis; CH=Chancroid						
Ocular manifestations	N	If event = some stage of syphilis, does the patient have ocular manifestations of syphilis?	193	1 = Yes, Verified 2 = Yes, Likely 3 = Yes, Possible 4 = No 9 = Unknown		
Otic manifestations	N	If event = some stage of syphilis, does the patient have otic manifestations of syphilis?	194	1 = Yes, Verified 2 = Yes, Likely 3 = Yes, Possible 4 = No 9 = Unknown		
Late clinical manifestations	N	If event = some stage of syphilis, does the patient have late clinical manifestations of syphilis?	195	1 = Yes, Verified 2 = Yes, Likely 4 = No 9 = Unknown		
Sexual orientation	N	Patient reported sexual orientation (i.e., person's physical and/or emotional attraction to individuals of the same gender, opposite gender or multiple genders)	196	1 = Gay or lesbian 2 = Straight, not gay or lesbian 3 = Bisexual 4 = Something else 9 = Unknown	Patient reported attraction to same, opposite or both genders; default to 9=Unknown if not ascertained for this case.	
Gender identity	N	Patient-reported gender identity (i.e., individual's personal sense of being male, female or transgender)	197	1 = Transgender male-to-female 2 = Transgender female-to-male 3 = Transgender unspecified 4 = Cisgender/Not transgender 9 = Unknown	Patient reported gender identity and transgender directionality; default to 9=Unknown if not ascertained for this case	
Case Sample	N	Indicates case randomly selected for enhanced investigation	198	Y = Yes N = No U = Unknown	Indicates whether case was **selected randomly** for enhanced investigation (as part of specific surveillance enhancement projects). Default to U=Unknown if no enhanced surveillance projects are implemented.	

National Electronic Telecommunications System for Surveillance (NETSS)
RECORD LAYOUT FOR TRANSMISSION OF STD MORBIDITY DATA
***CONGENITAL SYPHILIS* CASE RECORD (LINE-LISTED DATA)**
CDC 73.126 form was revised (02/2013)
(Effective as of January 2014)

CONGENITAL SYPHILIS

Data Element Name	*N/M	Columns	Data Element Definition/Values
CODE KEY *N=New (2013); M=Modified (2013)			
RECTYPE		1	Record type will determine how the record is handled when it arrives at CDC. Value for case data: *M=MMWR report*
UPDATE		2	**Currently not implemented.** (Pad with a 9)
STATE		3-4	Reporting State **FIPS** code - (e.g., "06", "13").
YEAR		5-6	MMWR Year (2-digits) for which case information reported to CDC.
CASEID		7-12	Unique Case ID **(numeric only)** assigned by the state.
SITE		13-15	Location code used by the state to indicate where report originated and who has responsibility for maintaining the record. (NOTE: STD*MIS software substitutes a '#' for the leading 'S' in codes listed below). Values include: *S01=State epidemiologist* *S02=State STD Program* *S03=State Chronic Disease Program* *S04-S99=Other state offices* *R01-R99=Regional or district offices* *001-999=County health depts (FIPS codes)* *L01-L99=Laboratories within state* *CD1=Historical records (prior to new format)* *CD2=Entered at CDC (based on phone reports)*
WEEK	M	16-17	*MMWR* Week on Surveillance Calendar. *MMWR* Week should be assigned using the date in the variable "Event Date."
EVENT		18-22	Event (disease) code for the disease being reported. Value: *10316=Syphilis (congenital)*
COUNT		23-27	*For case records this field will always contain "00001".*
COUNTY		28-30	FIPS code for reporting county (*999=Unknown*)
BIRTHDATE		31-38	Date of birth of infant in YYYYMMDD format *(99999999=Unknown*)
AGE		39-41	Estimated Gestational Age in weeks - (e.g., "038", "042") (*999= Unknown*)
AGETYPE		42	Indicates the units (weeks) for the AGE field. Values: *2=0-52 Weeks* *9=Gestational Age Unknown (AGE field should be 999)*
SEX (DISCONTINUED)	M	43	Gender. Value: 9=(Default)

Data Element Name	*N/M	Columns	Data Element Definition/Values
CODE KEY *N=New (2013); M=Modified (2013)			
			This variable should DEFAULT to 9. It is no longer being collected by DSTDP.
RACE	M	44	Race of Mother. Value: 9=(Default) This variable should DEFAULT to 9. It has been superseded by the individual RACE variables located in columns 238-244.
HISPANIC		45	Indicator for Mother's Hispanic ethnicity. Values: *1=Hispanic/Latino* *2=Non-Hispanic/Latino* *9=Unknown*
EVENTDATE		46-51	Date of Report to Health Department in YYMMDD format
DATETYPE		52	A code describing the type of date provided in EVENTDATE. Value: *4=Date of first report to community health system*
CASE STATUS		53	Recode of Case Classification. Values: *1=Confirmed, Probable, or Syphilitic stillbirth* *2=Not a case* *9=Unknown*
IMPORTED (DISCONTINUED)		54	Indicates if the case was imported into the state or the U.S. Value: *9=(Default)* This variable should default to 9. It has been superseded by the STD IMPORT variable located in Column 256.
OUTBREAK		55	Indicates whether the case was associated with an outbreak. Values: *1=Yes* *2=No* *9=Unknown*
FUTURE		56-60	Reserved for future use (Pad with 99999).
INFOSRCE		61-62	Information Source/Provider Codes (from Interview Record if available). Values: *01=HIV Counseling and Testing Site* *02=STD clinic* *03=Drug Treatment* *04=Family Planning* *06=Tuberculosis clinic* *07=Other Health Department clinic* *08=Private Physician/HMO* *10=Hospital-Emergency Room; Urgent Care Facility* *11=Correctional Facility* *12=Laboratory* *13=Blood Bank*
INFOSRCE (cont'd)			

Data Element Name	*N/M	Columns	Data Element Definition/Values
CODE KEY *N=New (2013); M=Modified (2013)			
			14=Labor and Delivery *15=Prenatal* *16=National Job Training Program* *17=School-based Clinic* *18=Mental Health Provider* *29=Hospital-Other* *66=Indian Health Service* *77=Military* *88=Other* *99=Unknown* (if data not available)
DETECTED	M	63-64	Method of Case Detection (from Interview Record if available). Values: *20=Screening* *21=Self-referred* *22=Patient referred partner* *23=Health Department referred partner* *24= Cluster related* *88=Other* *99=Unknown*
MZIP		65-69	Zip Code for Mother's Residence *99999=Unknown* (if data not available)
FUTURE	M	70-79	Reserved for future use (Pad with 9999999999)
CITY (DISCONTINUED)	M	80-83	Previously reporting City FIPS Code. Value: *9999=(Default)* This variable should DEFAULT to 9999. It is no longer being collected by DSTDP.
SENTINEL (DISCONTINUED)	M	84	Sentinel Reporting Site. Value: *9=(Default)* This variable should DEFAULT to 9. It is no longer being collected by DSTDP.
MSTATE		85-86	FIPS Code for Mother's State of Residence. Code 98 for Mexico and 97 for any other non-USA residence. (*99=Unknown*)
MCOUNTY		87-89	FIPS Code for Mother's County of Residence. Code 998 for Mexico and 997 for any other non-USA residence. (*999=Unknown*)
MCITY (DISCONTINUED)	M	90-93	Previously FIPS Code for Mother's City of Residence. Value: *9999=(Default)* This variable should DEFAULT to 9999. It is no longer being collected by DSTDP.
MBIRTH		94-101	Mother's Date of Birth in YYYYMMDD format. *(99999999=Unknown)*
MARITAL		102	Mother's Marital Status. Values:

Data Element Name	*N/M	Columns	Data Element Definition/Values
CODE KEY *N=New (2013); M=Modified (2013)			
			1=Single, never married *2=Married* *3=Separated/Divorced* *4=Widow* *8=Other* *9=Unknown*
LMP		103-110	Date of Mother's Last Menstrual Period before delivery in YYYYMMDD format. *(99999999=Unknown)*
PRENATAL	M	111	Did mother have prenatal care? Values: *0=No prenatal care* *1=Yes* *9=Unknown*
PNCDATE1		112-119	Date of mother's first prenatal visit in YYYYMMDD format. (*99999999=Unknown)*
PNCNUM (DISCONTINUED)	M	120-121	Number of prenatal visits. Value: *99=(Default)* This variable should DEFAULT to 99. It is no longer being collected by DSTDP.
NONTREP (DISCONTINUED)	M	122	Did mother have non-treponemal test (e.g., RPR or VDRL) in pregnancy, at delivery, or soon after delivery? Value: *9=(Default)* This variable should DEFAULT to 9. It is no longer being collected by DSTDP.
DATEA		123-130	Date of mother's most recent non-treponemal test in YYYYMMDD format. *(99999999=Unknown)*
RESULTA		131	Result of mother's most recent non-treponemal test. Values: *1=Reactive* *2=Nonreactive* *9=Unknown*
DATEB		132-139	Date of mother's first non-treponemal test in YYYYMMDD format. *(99999999=Unknown)*
RESULTB		140	Result of mother's first non-treponemal test. Values: *1=Reactive* *2=Nonreactive* *9=Unknown*
DATEC (DISCONTINUED)	M	141-148	Date of non-treponemal test in YYYYMMDD format. *99999999=(Default)* This variable should DEFAULT to 99999999. It is no longer being collected by DSTDP.

Data Element Name	*N/M	Columns	Data Element Definition/Values
CODE KEY *N=New (2013); M=Modified (2013)			
RESULTC (DISCONTINUED)	M	149	Result of non-treponemal test. Value: *9=(Default)* This variable should DEFAULT to 9. It is no longer being collected by DSTDP.
DATED (DISCONTINUED)	M	150-157	Date of non-treponemal test in YYYYMMDD format. *99999999=(Default)* This variable should DEFAULT to 99999999. It is no longer being collected by DSTDP.
RESULTD (DISCONTINUED)	M	158	Result of non-treponemal test. Value: *9=(Default)* This variable should DEFAULT to 9. It is no longer being collected by DSTDP.
TITER		159-162	Titer of mother's most recent non-treponemal test. (The titer for date b is in columns 214-217). *0=weakly reactive* *9999=Unknown* *Note: All entries should be left justified (no preceding or trailing zeroes). Example: If titer is 1:64, enter 64; if titer is 1:1024, enter 1024.*
TREPONEM (DISCONTINUED)	M	163	Did mother have confirmatory treponemal test result (e.g., FTA-ABS or MHATP)? Value: *9=(Default)* This variable should DEFAULT to 9. It is no longer being collected by DSTDP.
LESIONS (DISCONTINUED)	M	164	Did mother have darkfield or direct fluorescent antibody (DFA) exam of lesions at delivery? Value: *9=(Default)* This variable should DEFAULT to 9. It is no longer being collected by DSTDP.
LASTREAT (DISCONTINUED)	M	165	When was mother last treated for syphilis? Value: *9=(Default)* This variable should DEFAULT to 9. It is no longer being collected by DSTDP.
TXADQBEF (DISCONTINUED)	M	166	Before pregnancy, was mother's treatment adequate? Value: *9=(Default)* This variable should DEFAULT to 9. It is no longer being collected by DSTDP.
TXADQDUR (DISCONTINUED)	M	167	During pregnancy, was mother's treatment adequate? Value: *9=(Default)*

Data Element Name	*N/M	Columns	Data Element Definition/Values
CODE KEY *N=New (2013); M=Modified (2013)			
			This variable should DEFAULT to 9. It is no longer being collected by DSTDP.
RESPAPPR (DISCONTINUED)	M	168	Appropriate serologic response? Value: *9=(Default)* This variable should DEFAULT to 9. It has been superseded by the RESPAPP2 variable located in column 298.
VITAL		169	Vital status of infant/child. Values: *1=Alive* *2=Born alive, then died* *3=Stillborn* *9=Unknown*
DEATHDAT	M	170-177	Date of death of infant/child in YYYYMMDD format. *(If alive, pad with 99999999)* *(99999999=Unknown)*
BIRTHWT		178-181	Birthweight in grams *(9999=Unknown)*
REACSTS	M	182	Did infant/child have reactive non-treponemal test for syphilis? Values: *1=Yes* *2=No* *3=No test* *9=Unknown*
REACDATE		183-190	Date of infant/child's first reactive non-treponemal test for syphilis in YYYYMMDD format. *(99999999=Unknown)*
SIGNSCS (DISCONTINUED)	M	191	Did infant/child have any classic signs of CS? Value: *9=(Default)* This variable should DEFAULT to 9. It is no longer being collected by DSTDP.
DARKFLD	M	192	Did the infant/child, placenta, or cord have darkfield exam, DFA, or special stains? Values: *1=Yes, positive* *2=Yes, negative* *3=No test* *4=No lesions and no tissue to test* *9=Unknown*
DFA (DISCONTINUED)	M	193	Did infant/child have a direct fluorescent antibody test? Value: *9=(Default)* This variable should DEFAULT to 9. It is no longer being collected by DSTDP.

Data Element Name	*N/M	Columns	Data Element Definition/Values
CODE KEY *N=New (2013); M=Modified (2013)			
IGM (DISCONTINUED)	M	194	Did infant/child have an IgM-specific treponemal test? Value: *9=(Default)* This variable should DEFAULT to 9. It is no longer being collected by DSTDP.
XRAYS		195	Did infant/child have long bone x-rays? Values: *1=Yes, changes consistent with CS* *2=Yes, no signs of CS* *3=No x-rays* *9=Unknown*
CSFVDRL		196	Did infant/child have a CSF-VDRL? Values: *1=Yes, reactive* *2=Yes, nonreactive* *3=No test* *9=Unknown*
CSFCOUNT (DISCONTINUED)	M	197	Did infant/child have a CSF cell count or CSF protein test? Value: *9=(Default)* This variable should DEFAULT to 9. It is no longer being collected by DSTDP.
TREATED	M	198	Was infant/child treated? Values: *1=Yes, with Aqueous or Procaine Penicillin for 10 days* *3=Yes, with Benzathine penicillin x 1* *4=Yes, with other treatment* *5=No treatment* *9=Unknown* ***Note: 2=(Obsolete response)***
CLASS		199	Case Classification. Values: *1=Not a case* *2=Confirmed Case (laboratory confirmed identification of T.pallidum, e.g., darkfield or direct fluorescent antibody positive lesions)* *3=Syphilitic stillbirth* *4=Probable case (a case identified by the algorithm, which is not a confirmed case or syphilitic stillbirth)*
ID126		200-206	CDC 73.126 form Case ID number *(9999999=Unknown)*
VERSION	M	207-213	CDC 73.126 Form Version. Value: *02-2013*
TITERB		214-217	Titer of mother's first non-treponemal test b. *0=weakly reactive* *9999=Unknown*

Data Element Name	*N/M	Columns	Data Element Definition/Values
CODE KEY *N=New (2013); M=Modified (2013)			
			Note: All entries should be left justified (no preceding or trailing zeroes). Example: If titer is 1:64, enter 64; if titer is 1:1024, enter 1024.
TITERC (DISCONTINUED)	M	218-221	Titer of non-treponemal test c. Value: *9999=(Default)* This variable should DEFAULT to 9999. It is no longer being collected by DSTDP.
TITERD (DISCONTINUED)	M	222-225	Titer of non-treponemal test d. Value: *9999=(Default)* This variable should DEFAULT to 9999. It is no longer being collected by DSTDP.
TREATDAT (DISCONTINUED)	M	226-233	Date mother was treated in YYYYMMDD format. Value: *99999999=(Default)* This variable should DEFAULT to 99999999. It is no longer being collected by DSTDP.
INFTITER		234-237	Titer of infant/child's first reactive non-treponemal test for syphilis. *0=weakly reactive* *9999=Unknown* *Note: All entries should be left justified (no preceding or trailing zeroes). Example: If titer is 1:64, enter 64; if titer is 1:1024, enter 1024.*
			NOTE: If multiple races were selected and you entered code 8=Other for Race (column 44), please also select the appropriate race categories that apply in columns 238-244.
AMIND	M	238	American Indian/Alaskan Native: Values: 1 = Yes; Otherwise pad with a 9.
ASIAN	M	239	Asian: Values: 1 = Yes; Otherwise pad with a 9.
BLACK	M	240	Black: Values: 1 = Yes; Otherwise pad with a 9.
WHITE	M	241	White: Values: 1 = Yes; Otherwise pad with a 9.
NAHAW	M	242	Native Hawaiian or Other Pacific Islander: Values: 1 = Yes; Otherwise pad with a 9.

Data Element Name	*N/M	Columns	Data Element Definition/Values
CODE KEY *N=New (2013); M=Modified (2013)			
RACEOTH	M	243	Other Race: Values: 1 = Yes; Otherwise pad with a 9.
RACEUNK	M	244	Unknown Race: Values: 1 = Yes; Otherwise pad with a 9.
MCOUNTRY	M	245-246	Mother's country of residence. (XX=Unknown)
REACTREP	M	247	Did infant/child have reactive treponemal test? Values: *1 = Yes* *2 = No* *3 = No test* *9 = Unknown*
RTDATE		248-255	Date of infant/child's reactive treponemal test in YYYYMMDD format. *(99999999=Unknown)*
STD IMPORT		256	Was case imported? Was disease acquired elsewhere? Indicates probable location of disease acquisition relative to reporting state values. Values: *N = Not an imported case* *C = Yes, imported from another country* *S = Yes, imported from another state* *J = Yes, imported from another county/jurisdiction in the state* *D = Yes, imported but not able to determine source state and/or country* *U = Unknown*
GRAVIDA	N	257-258	Number of pregnancies (e.g. 01) *(99=Unknown)*
PARA	N	259-260	Number of live births (e.g. 03) (*99=Unknown)*
PNCTRI	N	261	Trimester of mother's first prenatal visit. Values: *1 = 1st trimester* *2 = 2nd trimester* *3 = 3rd trimester* *9 = Unknown*
TESTVISA	N	262	Did mother have non-treponemal or treponemal test at first prenatal visit? Values: *1 = Yes* *2 = No* *9 = Unknown*
TESTVISB	N	263	Did mother have non-treponemal or treponemal test at 28-32 weeks gestation? Values: *1 = Yes* *2 = No* *9 = Unknown*
TESTVISC	N	264	Did mother have non-treponemal or treponemal test at delivery? Values:

Data Element Name	*N/M	Columns	Data Element Definition/Values
CODE KEY *N=New (2013); M=Modified (2013)			
			1 = Yes *2 = No* *9 = Unknown*
TREPDTA	N	265-272	Date of mother's first treponemal test in YYYYMMDD format. *(99999999=Unknown)*
TESTTYPA	N	273	Test type of mother's first treponemal test. Values: *1 = EIA or CLIA* *2 = TP-PA* *3 = Other* *9 = Unknown*
TREPRESA	N	274	Result of mother's first treponemal test. Values: *1 = Reactive* *2 = Nonreactive* *9 = Unknown*
TREPDTB	N	275-282	Date of mother's most recent treponemal test in YYYYMMDD format. *(99999999=Unknown)*
TESTTYPB	N	283	Test type of mother's most recent treponemal test. Values: *1 = EIA or CLIA* *2 = TP-PA* *3 = Other* *9 = Unknown*
TREPRESB	N	284	Result of mother's most recent treponemal test. Values: *1 = Reactive* *2 = Nonreactive* *9 = Unknown*
HIVSTAT	N	285	What was mother's HIV status during pregnancy? Values: *P = Positive* *E = Equivocal test* *X = Patient not tested* *N = Negative* *U = Unknown*
CLINSTAG	N	286	What clinical stage of syphilis did mother have during pregnancy? Values: *1 =Primary* *2 = Secondary* *3 = Early latent* *4 = Late or late latent* *5 = Previously treated/serofast* *8 = Other* *9 = Unknown*

Data Element Name	*N/M	Columns	Data Element Definition/Values
CODE KEY *N=New (2013); M=Modified (2013)			
SURVSTAG	M	287	What surveillance stage of syphilis did mother have during pregnancy? Values: *1 = Primary* *2 = Secondary* *3 = Early non-primary, non-secondary* *4 = Unknown Duration or Late (previously referred to as Late or Late Latent)* *8 = Other* *9 = Unknown*
FIRSTDT	N	288-295	Date of mother's first dose of benzathine penicillin in YYYYMMDD format. *(99999999=Unknown)*
FIRSTDOS	N	296	When did mother receive her first dose of benzathine penicillin? Values: *1 = Before pregnancy* *2 = 1st trimester* *3 = 2nd trimester* *4 = 3rd trimester* *5 = No Treatment* *9 = Unknown*
MOMTX	N	297	What was mother's treatment? Values: *1 = 2.4 M units benzathine penicillin* *2 = 4.8 M units benzathine penicillin* *3 = 7.2 M units benzathine penicillin* *8 = Other* *9 = Unknown*
RESPAPP2	N	298	Did mother have an appropriate serologic response? Values: *1 = Yes, appropriate response* *2 = No, inappropriate response: evidence of treatment failure or reinfection* *3 = Response could not be determined from available non-treponemal titer information* *4 = Not enough time for titer to change*
			NOTE: Did the infant/child have any signs of CS? (check all that apply in columns 299-308)
CLINNO	N	299	No signs/asymptomatic? Values: *1 = Yes; Otherwise pad with a 9.*
CLINLATA	N	300	Condyloma lata? Values: *1 = Yes; Otherwise pad with a 9.*
CLINSNUF	N	301	Snuffles? Values: *1 = Yes; Otherwise pad with a 9.*

Data Element Name	*N/M	Columns	Data Element Definition/Values
CODE KEY *N=New (2013); M=Modified (2013)			
CLINRASH	N	302	Syphilitic skin rash? Values: *1 = Yes; Otherwise pad with a 9.*
CLINHEPA	N	303	Hepatosplenomegaly? Values: *1 = Yes; Otherwise pad with a 9.*
CLINJUAN	N	304	Jaundice/Hepatitis? Values: *1 = Yes; Otherwise pad with a 9.*
CLINPARA	N	305	Pseudo paralysis? Values: *1 = Yes; Otherwise pad with a 9.*
CLINEDEM	N	306	Edema? Values: *1 = Yes; Otherwise pad with a 9.*
CLINOTH	N	307	Other signs of CS? Values: *1 = Yes; Otherwise pad with a 9.*
CLINUNK	N	308	Unknown signs of CS? Values: *1 = Yes; Otherwise pad with a 9.*
CSFWBC	N	309	Did the infant/child have a CSF WBC count or CSF protein test? Values: *1 = Yes, CSF WBC count elevated* *2 = Yes, CSF protein elevated* *3 = Both tests elevated* *4 = Neither test elevated* *5 = No test* *9 = Unknown*

National Electronic Telecommunications System for Surveillance (NETSS)
RECORD LAYOUT FOR TRANSMISSION OF STD MORBIDITY DATA
DELETION RECORDS

Data Element Name	Columns	Data Element Definition/Values
RECTYPE	1	Record type will determine how the record is handled when it arrives at CDC. Value for deletion record: *D=Delete*
UPDATE	2	**Currently not implemented.**
STATE	3-4	Reporting State **FIPS** code - Q2 on 126 form.(e.g., "06", "13").
YEAR	5-6	MMWR Year (2-digits) in which record to be deleted was reported to CDC.
CASEID	7-12	Unique Case ID **(numeric only)** assigned by the state.
SITE	13-15	Location code used by the state to indicate where report originated and who has responsibility for maintaining the record. (NOTE: STD*MIS software substitutes a '#' for the leading 'S' in codes listed below). Values include: *S01=State epidemiologist* *S02=State STD Program* *S03=State Chronic Disease Program* *S04-S99=Other state offices* *R01-R99=Regional or district offices* *001-999=County health depts (FIPS codes)* *L01-L99=Laboratories within state* *CD1=Historical records (prior to new format)* *CD2=Entered at CDC (based on phone reports)*
WEEK	16-17	MMWR Week on Surveillance Calendar, i.e., week in which record to be deleted was reported to CDC.
FILLER	18-60	Blank

National Electronic Telecommunications System for Surveillance (NETSS)
RECORD LAYOUT FOR TRANSMISSION OF STD MORBIDITY DATA
VERIFICATION RECORDS

Data Element Name	Columns	Data Element Definition/Values
RECTYPE	1	Record type will determine how the record is handled when it arrives at CDC. Value for verification record: *V=Verification*
STATE	2-3	Standard Reporting State **FIPS** code.(e.g., "06", "13").
EVENT	4-8	Event (disease) code for the disease being reported. *STD Codes:* *10273=Chancroid* *10274=Chlamydia trachomatis infection* *10280=Gonorrhea* *10311=Syphilis (primary)* *10312=Syphilis (secondary)* *10313=Syphilis, early latent* *10314=Syphilis, late latent* *10316=Syphilis (congenital)* *10319=Syphilis, late with clinical manifestations (including late benign syphilis and cardiovascular syphilis)*
COUNT	9-13	Number of cases reported year-to-date.
YEAR	14-15	Year (2-digits) in which verification record is being transmitted to CDC.
FILLER	16-60	Blank

ATTACHMENT B

EXAMPLE OF TRANSMISSION SUMMARY REPORT

NNDSS STATE'S STATUS-SUMMARY REPORT

WEEK 50 , WEEK ENDING DATE:12/15/2007

TABLE 1 PROCESS DATE: 12/18/2007

ANY STATE PROCESS TIME: 11:31

FILENAME FOR LOAD: R:\LINK\MMWRPROD\INNET77\MDN01919.STD

SUMMARY TOTALS OF THIS WEEK'S REPORT

TOTAL RECORDS RECEIVED	928
NUMBER OF NEW RECORDS ADDED TO DATABASE	553
NUMBER OF UPDATE/DELETION RECORDS	353
NUMBER OF VERIFICATION RECORDS	9
NUMBER OF NON_NOTIF RECORDS NOT ADDED TO DATABASE	0
NUMBER OF INVALID RECORDS NOT ADDED TO DATABASE	5

TABLE 2 PROCESS DATE: 12/18/2007

ANY STATE PROCESS TIME: 11:31

THE FOLLOWING DIFFERENCES WERE NOTED BETWEEN THE CDC/DHIS DATABASE AND THE VERIFICATION RECORDS SENT FROM THE STATE DATABASE

PLEASE RECONCILE THE COUNTS; CALL THE GENERAL BRANCH NUMBER @ (404) 498-6241 FOR ASSISTANCE, IF NECESSARY. PLEASE TRANSMIT CHANGES AND CORRECTIONS AS SOON AS POSSIBLE

EVENT	CDC	STATE	DIFFERENCE
ASEPTIC MENINGITIS	493		493+
BACTERIAL MENING., OTHER	58		58+
CHANCROID	1	1	
CHICKENPOX (VARICELLA)	6		6+
CHLAMYDIA TRACHOMATIS	19388	19378	10+
FLU ACTIVITY CODE	109		109+
GIARDIASIS	249		249+
GONORRHEA	5855	5850	5+
HAEMOPHILUS INFLUENZAE	79		79+
HEPATITIS B, V. ACUTE	125		125+
HEPATITIS C, V. ACUTE	29		29+
LEGIONELLOSIS	84		84+
LYME DISEASE	3019		3019+
MALARIA	63		63+
MENINGOCOCCAL DISEASE	20		20+
MUMPS	16		16+
PERTUSSIS	120		120+
RABIES, ANIMAL	327		327+
ROCKY MOUNTAIN SP. FEVER	90		90+
RUBELLA	1		1+
SALMONELLOSIS	865		865+
SHIGELLOSIS	113		113+
STAPHYLOCOCCUS (MRSA)	3		3+
STREPTOCOCCAL DISEASE, INV.GROUP A	207		207+
STREPTOCOCCAL DISEASE, INV.GROUP B	452		452+
SYPHILIS, CONGENITAL	15	15	
SYPHILIS, EARLY LATENT	283	279	4+
SYPHILIS, LATE LATENT	323	320	3+
SYPHILIS, LATE W/CLIN.	5	5	
SYPHILIS, PRIMARY	80	78	2+
SYPHILIS, SECONDARY	216	215	1+
TUBERCULOSIS	250		250+
TYPHOID FEVER	16		16+

* STATE HAS MORE RECORDS THAN CDC/DHIS. PLEASE CHECK FILES AND TRANSMIT ANY ADDITIONAL RECORDS.
\+ CDC\DHIS HAS MORE RECORDS THAN STATE. PLEASE CHECK FILES AND TRANSMIT APPROPRIATE DELETIONS.

TABLE 3 PROCESS DATE: 12/18/2007

ANY STATE PROCESS TIME: 11:31

UPDATES AND DELETIONS PERFORMED AND POSSIBLE ERRORS DETECTED

YEAR	WEEK	SITE	CASEID	EVENT NAME	MESSAGE
2007	45	#01	48982	EVENT CODE INVALID	RECORD DELETED
2007	49	#01	50162	EVENT CODE INVALID	RECORD DELETED
2007	49	#01	50280	EVENT CODE INVALID	RECORD DELETED
2007	40	#01	1684	GONORRHEA	RECORD UPDATED
2007	40	#01	1688	CHLAMYDIA	INVALID RECORD TYPE: K *(INVALID RECORD)
2007	25	#01	1693	CHANCROID	INVALID STATE CODE: 88 *(INVALID RECORD)
2007	40	#01	1694	CHLAMYDIA	RECORD UPDATED
2006	40	#01	1696	GONORRHEA	DATABASE CLOSED FOR YEAR: 06 *(INVALID RECORD)
2007	54	#01	1707	SYPHILIS, PRIM	INVALID WEEK NUMBER: 54 *(INVALID RECORD)

*(INVALID RECORD) - RECORD NOT ADDED TO DATABASE. PLEASE SEND CORRECTED RECORD.
(WARNING) - RECORD ADDED TO DATABASE. PLEASE SEND CORRECTIONS TO RECORD.

Summary of Revisions

in the

National Electronic Telecommunications System for Surveillance (NETSS)

RECORD LAYOUT FOR TRANSMISSION OF STD MORBIDITY DATA

Effective as of January 2018

All modifications to Version 5 (January 2018) of the NETSS record layout for transmission of STD morbidity data are denoted by 'M' (M=Modified (2018)) in the column labeled "*N/M".

Assignment of New Event Code

As of January 2018, a new event code has been assigned for the data element, EVENT or DIAGNOSIS. The code is:

10320 = Syphilis, unknown duration or late

NOTE: Cases previously assigned to event code 10314 (Late latent syphilis) should be mapped to event code 10320. Cases previously assigned to event code 10319 (Syphilis, late with clinical manifestations) should be mapped to event code 10320 and the data element LATE CLINICAL MANIFESTATIONS should be coded as 1 = Yes, Verified or 2 = Yes, Likely, based on criteria described in CSTE syphilis case definition.

Retirement of Event Codes

As of January 2018, two codes will be retired for the data element, EVENT or DIAGNOSIS. The retired codes are:

10314 = Late latent syphilis

10319 = Syphilis, late with clinical manifestations (including late benign syphilis and cardiovascular syphilis)

Renamed Event Code

As of January 2018, an event code has been renamed for the data element, EVENT or DIAGNOSIS. The renamed code is:

10313 = Syphilis, early non-primary non-secondary

NOTE: No changes have been made to the case definition; therefore, all cases meeting the case definition of "Early latent syphilis" that were coded as event code 10313 should continue to be coded as event code 10313.

Retirement of a Data Element

As of January 2018, one data element has been retired. The retired data element is:

NEUROLOGICAL INVOLVEMENT (column 95). Values for this data element should be set to 9. This data element has been superseded by the NEUROLOGIC MANIFESTATIONS data element located in column 192

Addition of New Data Elements

As of January 2018, six new data elements have been added. The added data elements are:

NEUROLOGIC MANIFESTATIONS (column 192); Required for syphilis

OCULAR MANIFESTATIONS (column 193); Required for syphilis

OTIC MANIFESTATIONS (column 194); Required for syphilis

LATE CLINICAL MANIFESTATIONS (column 195); Required for syphilis

SEXUAL ORIENTATION (column 196); Optional chlamydia, gonorrhea, syphilis, and chancroid

GENDER IDENTITY (column 197); Optional chlamydia, gonorrhea, syphilis, and chancroid

CASE SAMPLE (column 198); Optional chlamydia, gonorrhea, syphilis, and chancroid

Revision to Coding Guidance

As of January 2016, coding guidance has been revised for a number of data elements.

To increase comparability across jurisdictions the following guidance has been provided for coding of EVENT DATE, DATETYPE, WEEK:

The date provided in EVENT DATE should most closely approximate the date of disease onset (incidence) and should be based on the following hierarchy:

- Date of disease onset
- Date of diagnosis (proxy: Date of laboratory specimen collection)
- Date of laboratory result
- Date of first report to public (community) health system
- State or *MMWR* report date

When date of diagnosis or date of laboratory result are not readily available, but date of laboratory specimen collection date is available, date of laboratory specimen collection should be considered a proxy for date of diagnosis and should be used to assign EVENT DATE.

If date of laboratory specimen collection is used to assign EVENT DATE, date of diagnosis should be selected as the value for DATETYPE.

The date in the data element EVENT DATE should be used to assign the data element WEEK.

To align with current CSTE case definitions, the case classification of “suspect” has been removed from the description of the following EVENT CODES:

10273 = Chancroid

10280 = Gonorrhea

10313 = Syphilis, early non-primary non-secondary

10320 = Syphilis, unknown duration or late

To align with current CSTE case definitions, the case classification of “suspect” and “probable” have been removed from the description of the following EVENT CODE:

10274=*Chlamydia trachomatis* infection

The embedded links to websites have been updated in the descriptions of the data elements STATE and CASE STATUS.

Summary of Revisions

in the

National Electronic Telecommunications System for Surveillance (NETSS)

RECORD LAYOUT FOR TRANSMISSION OF STD MORBIDITY DATA: CONGENITAL SYPHILIS

Effective as of January 2018

All modifications to Version 5 (January 2018) of the NETSS record layout for transmission of Congenital Syphilis morbidity data are denoted by 'M' (M=Modified (2018)) in the column labeled "*N/M".

Revision to Value Set

As of January 2016, the value set for the data element SURVSTAG (column 287) in the Congenital Syphilis Case Record has been updated:

1 = Primary
2 = Secondary
3 = Early Non-Primary, Non-Secondary (previously referred to as Early Latent)
4 = Unknown Duration or Late (previously referred to as Late or Late Latent
8 = Other
9 = Unknown

NOTE: At this time, the hard copy congenital syphilis case report form will not be updated to reflect this revision. If you are reporting a congenital syphilis case via hardcopy, please use the value set above.

Revision to Coding Guidance

As of January 2016, coding guidance has been revised for a one data element.

The data element *WEEK* should be assigned using the date in the data element EVENT DATE.