

SEXUALLY TRANSMITTED DISEASE - CONFIDENTIAL MORBIDITY REPORT

Date of Report: - - ☐ New

Medical record attached

Date of Report: - - ☐ UpdateReport Done by: **Diagnosing Medical Practitioner Information** (Write legibly or use clinic stamp. For a custom form with your information, email stdreporting@ph.lacounty.gov)

Provider Name:

Dept./Clinic:

Facility Name:

Address:

City/State/Zip Code:

Telephone Number:

Fax Number:

PATIENT'S LAST NAME

FIRST NAME

M.I.

MEDICAL RECORD NUMBER

BIRTHDATE

AGE

PATIENT'S STREET ADDRESS

APT/UNIT NO.

CITY/TOWN

STATE

ZIP CODE

HOME TEL.

WORK TEL.

UNSTABLE HOUSING/UNHOUSED

CELL

E-MAIL ADDRESS

Patient Pregnant? ☐ Unk. ☐ No ☐ Yes ▶LMP (mm/dd/yy):Partner Pregnant? ☐ Unk. ☐ No ☐ Yes**Gender:**

- ☐ Male
☐ Female
☐ Transgender MtoF
☐ Transgender FtoM
☐ Unknown
☐ Other

Marital Status:

- ☐ Single
☐ Married/
 Domestic Partnership
☐ Separated
☐ Divorced
☐ Widowed
 Living with Partner

Race(s):

- ☐ White
☐ Black/African American
☐ Native American/Alaska Native
☐ Asian/Asian American
☐ Native Hawaiian/ Pacific Islander
☐ Unknown
 Other: _____

Ethnicity:

- ☐ Hispanic/Latino/a
☐ Non-Hispanic/
 Non-Latino/a

Primary Language:

- ☐ English
☐ Spanish
☐ Other: _____

Gender of Sex Partner(s):

- ☐ Male
☐ Female
☐ Transgender MtoF
☐ Transgender FtoM
☐ Other
☐ Unknown
☐ Refused

Disease(s) Being Reported: ☐ Chancroid ☐ Gonorrhea ☐ Syphilis (for syphilis fill out back of form & fax both sides)

Site/specimen(s) with positive result:

Gonorrhea

- ☐ Urine
☐ Cervix
☐ Vagina
☐ Urethra
☐ Rectum
☐ Pharyngeal
☐ Other: _____

Specimen collection date (mm/dd/yy):

Treatment date (mm/dd/yy):

Allergic to: ☐ Penicillin ☐ CephalosporinsMedication(s) and Doses: ☐ Not treated

- ☐ Ceftriaxone 500mg
☐ Ceftriaxone 1g IM
☐ Azithromycin 2g po
☐ Cefixime 800mg po
☐ Gentamicin 240 mg IM
 Other med(s): _____

Doxycycline 100mg po
 DoxyPEP (Doxycycline 200mg po)

Gonorrhea Diagnosis

- ☐ Asymptomatic
☐ Symptomatic - uncomplicated
 Eye infection
☐ Disseminated gonorrhea (DGI)
☐ Other: _____

Partner Info.:

Number Partners
 (last 60 days):

Number Treated (not including PDPT):

Number Given PDPT (Patient Delivered Partner Therapy):

PATIENT'S LAST NAME

FIRST NAME

M.I.

PATIENT'S DATE OF BIRTH

PROVIDER NAME

PROVIDER TEL #

PROVIDER FAX #

Syphilis

Syphilis stage

- ☐ Primary (lesion/sore present)
- ☐ Secondary (rash/condyloma lata present)
- Early latent (≤ 1 year)
- Late latent (> 1 year)
- Probable Congenital syphilis
- Neurosyphilis (if checked, indicate stage above)

Symptoms/Signs

- ☐ None ☐ Genital ulcer ☐ Rectal/perianal ulcer ☐ Oral ulcer
- ☐ Rash ☐ Palmar/Plantar ☐ Condyloma lata ☐ Otic
- ☐ Neurological symptoms ☐ Ocular

Other: _____

Onset Date (mm/dd/yy): _____

Laboratory Name: _____

Blood test - collection date (mm/dd/yy): _____

RPR ☐ Neg ☐ Pos: } Titer 1: _____

VDRL ☐ Neg ☐ Pos: }

FTA-ABS ☐ Neg ☐ Pos

TP-PA ☐ Neg ☐ Pos

EIA/CIA ☐ Neg ☐ Pos

Other (test name/result): _____

CSF - collection date (mm/dd/yy): _____

CSF-VDRL ☐ Neg ☐ Pos: Titer 1: _____

CSF WBC _____ mm3 CSF protein _____ mg/dl

Infants only ☐ Live birth ☐ Still birth Neonatal death
(Death <29 days after birth)

Gestation _____ weeks Weight _____ grams

Long bone x-rays consistent ☐ No ☐ Unknown
with congenital syphilis? ☐ Yes ☐ Not done

Infant's serum RPR titer 4X mothers? ☐ No ☐ Yes

Mothers only (complete only if this is baby's CMR)

Syphilis stage: _____ Neurosyphilis

Serology (at delivery) ☐ RPR ☐ VDRL Titer 1: _____

Rx (meds & date/s): _____

Partner Information

Number Partners _____ Number _____
(last 12 months): Treated: _____

Patient Rx - Medication(s) and Doses:

Treatment date(mm/dd/yy):

Allergic to: ☐ Penicillin ☐ Cephalosporins

☐ Not treated

☐ Bicillin LA or Extencilline 2.4MU IM once

☐ Bicillin LA or Extencilline 2.4MU IM once

☐ Bicillin LA or Extencilline 2.4MU IM once

Doxycycline 100mg bid x 14 d

☐ Doxycycline 100mg bid x 28 d

Ceftriaxone 1 g IM or IV x10-14 d

DoxyPEP (Doxycycline 200mg po)

Treatment start date(mm/dd/yy):

Treatment end date(mm/dd/yy):

Aqueous crystalline penicillin G 18-24MU IV

Other meds: _____

Treatment date(mm/dd/yy):

CONGENITAL SYPHILIS

Provide info. below on MOTHER(if this is infant's CMR) or INFANT (if this is mother's CMR).

Send CMRs for both mother & infant

LAST NAME

FIRST NAME

MEDICAL RECORD NUMBER

BIRTHDATE

FAX TO: (213) 749-9602 OR MAIL TO:
County of Los Angeles, Department of
Public Health, DHSP/STD
555 W. 5th Street, 34th Floor,
Los Angeles, CA 90013

Complete STD CMR on-line or download at:
<http://publichealth.lacounty.gov/dhsp/InfoForProviders.htm>
For a custom electronic or printed form, prepopulated with your information, contact:
stdreporting@ph.lacounty.gov or (213) 741-8000. Do not send completed forms by email.
For info. on STD reporting: <http://publichealth.lacounty.gov/dhsp/ReportCase.htm> (213) 368-7441
For info. on HIV reporting: <http://publichealth.lacounty.gov/dhsp/ReportCase.htm> (213) 351-8516