SEXUALLY TRANSMITTED DISEASE - CONFIDENTIAL MORBIDITY REPORT

County of Los Angeles Public Health

Date of Report: ☐☐ - ☐☐ - ☐☐ ☐ New

Date of Report: ☐☐ - ☐☐ - ☐☐ ☐ Update

Report 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.

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 ☐ Cephalosporins

Medication(s) and Doses: ☐Not treated

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

☐ Doxycycline 200mg po (Doxy-PEP)
☐ Doxycycline 100mg po
☐ DoxyPEP

Gonorrhea Diagnosis
☐ Asymptomatic
☐ Symptomatic - uncomplicated
☐ Eye infection
☐ Disseminated gonorrhea
☐ 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:	} Titer 1:
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

Gestation ___ weeks Weight ___ grams

Long bone x-rays consistent with congenital syphilis? ☐ No ☐ Unknown ☐ 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 (last 12 months): Number Treated:

Patient Rx - Medication(s) and Doses:

Treatment date(mm/dd/yy):

Allergic to: ☐ Penicillin ☐ Cephalosporins ☐ Not treated

- ☐ Benzathine penicillin G 2.4MU IM once
- ☐ Benzathine penicillin G 2.4MU IM once
- ☐ Benzathine penicillin G 2.4MU IM once
- ☐ Doxycycline 100mg bid x 14 d
- ☐ Doxycycline 100mg bid x 28 d

Treatment date(mm/dd/yy):

- ☐ Ceftriaxone 1 g IM or IV x10-14 d
- ☐ DoxyPEP

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 | M.I.

MEDICAL RECORD NUMBER | BIRTHDATE

FAX TO: (213) 749-9602 OR

MAIL TO:

Division of HIV and STD Programs
600 S. Commonwealth Ave., 10th Floor,
Los Angeles, CA 90005

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