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**: ☐☐ - ☐☐ - ☐☐ **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

Races(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: ☐**Chlamydia** (including LGV) ☐**Gonorrhea** ☐**Syphilis** (for syphilis fill out back of form & fax both sides) ☐**Chancroid**

Site/specimen(s) with positive result:

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

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

Specimen collection date: ☐☐ - ☐☐ - ☐☐

Treatment date: ☐☐ - ☐☐ - ☐☐

Allergic to: ☐Penicillin ☐Cephalosporins

Medication(s) and Doses: ☐Not treated
☐Ceftriaxone 250mg IM
☐Azithromycin 1g po
☐Azithromycin 2g po
☐Doxycycline 100mg bid x 7d
☐Doxycycline 200mg q day x 7d
☐Cefixime 400mg po
☐Gentamicin 240 mg IM
☐Other med(s):_____

Chlamydia/Gonorrhea Diagnosis
☐Asymptomatic
☐Symptomatic - uncomplicated
☐Eye infection
☐Disseminated gonorrhea
☐Lymphogranuloma venereum (LGV)
☐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

Symptoms/Signs

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

Onset Date: - -

Laboratory Name: _____

Blood test - collection date: - -

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: - -

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: _____

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(s):**

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 - -

☐ Other med(s): _____

Treatment date(s): - -

_____ - -

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,
Suite 1280, 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