

**WEEKLY LABORATORY REPORT OF SEXUALLY TRANSMITTED DISEASES**  
**CHICAGO DEPARTMENT OF PUBLIC HEALTH - STD SECTION**  
*Chlamydia and Gonorrhea*

FOR THE WEEK ENDING SATURDAY «Dates»

Laboratory Name	«Providers»
STD Laboratory Number	«Provider_Code»

**PLEASE LIST INFORMATION ON PERSONS WITH POSITIVE TEST(S) FOR CHLAMYDIA AND/OR**

NAME OF LAB WHERE TEST WAS DONE (IF OTHER)	PATIENT'S NAME ADDRESS & PHONE	RACE/ ETHN SEX	Date Of Birth	PHYSICIAN'S NAME, CITY, PHONE, AND FAX NUMBER	TEST DATE	REASON FOR TEST*	DISEASE/TEST MARK BOX(ES)
		B W H O M F					GONORRHEA: CHLAMYDIA:
		B W H O M F					GONORRHEA: CHLAMYDIA:
		B W H O M F					GONORRHEA: CHLAMYDIA:
		B W H O M F					GONORRHEA: CHLAMYDIA:
		B W H O M F					GONORRHEA: CHLAMYDIA:
		B W H O M F					GONORRHEA: CHLAMYDIA:
		B W H O M F					GONORRHEA: CHLAMYDIA:
		B W H O M F					GONORRHEA: CHLAMYDIA:
		B W H O M F					GONORRHEA: CHLAMYDIA:

\*Reason for Test: "D" for Diagnostic, "P" for Prenatal, "S" for Screening, "T" for Treatment

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The Illinois Department of Public Health is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Illinois Sexually Transmissible Disease Control Act (Ill. Rev. Stat. 1987, ch. 111 1/2, par. 7401 et seq.). Disclosure of this information is MANDATORY. This form has been approved by the Forms Management Center.

**WEEKLY LABORATORY REPORT OF SEXUALLY TRANSMITTED DISEASES**  
**CHICAGO DEPARTMENT OF PUBLIC HEALTH - STD SECTION**  
*Syphilis*

FOR THE WEEK ENDING SATURDAY «Dates»

Laboratory Name	«Providers»
STD Laboratory Number	«Provider_Code»

**PLEASE LIST INFORMATION ON PERSONS WITH POSITIVE TEST(S) FOR SYPHILIS**

NAME OF LAB WHERE TEST WAS DONE (IF OTHER)	PATIENT'S NAME AND ADDRESS	RACE/ETHN. SEX				Date of Birth	PHYSICIAN'S NAME, CITY, PHONE, AND FAX NUMBER	TEST DATE	REASON FOR TEST*	RPR (titer)	VDRL (titer)	TPPA Or FTA**	EIA	DARK FIELD
		B	W	H	O									
		B	W	H	O									
		M			F									
		B	W	H	O									
		M			F									
		B	W	H	O									
		M			F									
		B	W	H	O									
		M			F									
		B	W	H	O									
		M			F									

\*Reason for Test: "D" for Diagnostic, "P" for Prenatal, "S" for Screening, "T" for Treatment, \*\*Circle either TPPA or FTA to indicate which test was performed

**RECOMMENDATIONS**

**SYPHILIS**

A reactive RPR or VDRL should have a confirmatory test for syphilis performed, e.g., FTA-ABS or MHA-TP, unless the client has a previous history of a reactive confirmatory test. A reactive RPR or VDRL may be submitted to an IDPH Laboratory for a confirmatory test.

**Location of IDPH Laboratory: 2121 W. Taylor St.  
 Chicago 60612  
 (312) 793-4760**