CONFIDENTIAL MORBIDITY REPORT OF SEXUALLY TRANSMITTED INFECTIONS

CHICAGO DEPARTMENT OF PUBLIC HEALTH, STI SURVEILLANCE UNIT 333 S. STATE STREET CHICAGO, IL 60604
Phone: 312-747-0697 Fax: 312-745-7627

Report

Date of report ___/___/_____ Attending _____ *Testing* *Treating* Phone (_____)_____

Facility _____ Dept/Clinic _____ Address _____

City _____ State Zip Person completing form _____ Phone (_____)_____

Patient

Please check all that apply.

First name _____ Last name _____ Middle initial _____

Address _____ Apt # _____ City _____ State _____ Zip _____

County _____ Phone (_____)_____ Date of birth ___/___/_____ Age_____

Race White Black/African-American
Asian Native American/Alaskan
Native Hawaiian/Other Pacific Islander
Unknown Other _____

Ethnicity Hispanic/Latino Non-Hispanic/Latino Unknown

Sex Male Female Transgendered: M-to-F Transgendered: F-to-M

Sex of partners Male Female Unk Transgendered: M-to-F Transgendered: F-to-M

Pregnant? Yes, due date___/___/_____ No Unk

Diagnosis

Please check all that apply.

CHLAMYDIA	GONORRHEA
Genito-urinary	Genito-urinary
Ophthalmia	Ophthalmia
Pneumonia	Pharyngeal
PID	Rectal
Pharyngeal	DGI
Rectal	PID
Other	Other

SYPHILIS

Stage Primary Secondary Early latent (<1 yr) Late latent (>1 yr)
Latent (duration unknown) Late symptomatic Stage unknown

Symptoms/Signs Lesion (ulcer) Rash: _____
No symptoms Unknown Other _____

Neurological Confirmed (positive CSF-VDRL) Probable (negative CSF-VDRL)

Previous infection

Laboratory

Please report all positive lab

CHLAMYDIA	GONORRHEA
___/___/_____ (Date positive test collected)	___/___/_____ (Date positive test collected)
DNA Probe	DNA Probe
NAAT	NAAT
Culture	Culture
Other _____	Gram Stain
	Other _____

SYPHILIS *Please check the serological test used for the screening & confirmatory tests.*

Serologic Screening Test
RPR VDRL Titer 1:_____
Date:___/___/_____
Result: Positive Negative Equivocal

Serologic Confirmatory Test
FTA-ABS TP-PA EIA MHA-TP
Date: ___/___/_____
Result: Positive Negative Equivocal

Darkfield / DFA-TP
Date: ___/___/_____
Result: Positive Negative Equivocal

CSF- VDRL WBC_____ Protein ____
Date: ___/___/_____
Result: Positive Negative Equivocal

Treatment

Please check all treatments given.

CHLAMYDIA

Azithromycin 1 g x 1 **or**
Doxycycline 100 mg BID x 7d

Alternate regimens

Amoxicillin 500 mg TID x 7d
Erythromycin base 250 mg QID x 14d
Erythromycin base 500 mg QID x 7d
Erythromycin ethylsuccinate 800 mg QID x 7d
Levofloxacin 500 mg x 1 x 7d
Ofloxacin 300 mg BID x 7d
IV Therapy _____
Other _____
No treatment given

Treatment date: ___/___/_____

GONORRHEA

Ceftriaxone 250 mg IM x 1 **plus**
Azithromycin 1 g x 1 **or**
Ceftriaxone 250 mg IM x 1 **plus**
Doxycycline 100 mg BID x 7d

Alternate regimens

Cefixime 400 mg x 1 **plus**
Azithromycin 1 g x 1 **plus test of cure in 1 week**
Cefixime 400 mg x 1 **plus**
Doxycycline 100 mg BID x 7d **plus test of cure in 1 week**
Azithromycin 2g x1 **plus test of cure in 1 week**
IV Therapy _____
Other _____
No treatment given

Treatment date: ___/___/_____

SYPHILIS

Benzathine Penicillin G 2.4 MU IM x 1
Benzathine Penicillin G 2.4 MU IM x 3wks
Aqueous Crystalline Penicillin G 3-4 MU IV x 10-14d

Alternate regimens

Procaine PCN 2.4 MU IM x 1 **plus**
Probenecid 500 mg QID, both x 10-14d
Doxycycline 100 mg BID x 14d
Doxycycline 100 mg BID x 28d
Other _____
No treatment given

Multiple treatments? Please use comment area.

Treatment date: ___/___/_____

Comments

Rev 4/15/14

CDPH ONLY
Date Received: ___/___/_____ Patient's Record #: _____ Assigned to: _____ Phone (_____)_____