

SEXUALLY TRANSMITTED INFECTION - CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting only Sexually Transmitted Infections. For HIV/AIDS reporting, call (805) 652-5780.

Date of Report: ____ - ____ - ____ New

Date of Report: ____ - ____ - ____ Update **Report Done by:** _____

Diagnosing Medical Practitioner Information (Write legibly or use clinic stamp.)

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	Birth Date (mm/dd/yyyy)		Age	Weight
Patient's Street Address			Apt./Unit No.	
City/Town		State	ZIP Code	
Home Telephone Number		Work Telephone Number		
Cell Telephone Number		E-mail Address		

Patient Pregnant? Unk. No Yes → **LMP:** ____ - ____ - ____ **Partner Pregnant?** Unk. No Yes

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender MtoF <input type="checkbox"/> Transgender FtoM <input type="checkbox"/> Unknown <input type="checkbox"/> Other	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married/ Domestic Partnership <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living with Partner	Races(s): <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Asian/Asian American <input type="checkbox"/> Native Hawaiian/ Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____	Ethnicity: <input type="checkbox"/> Hispanic/Latino/a <input type="checkbox"/> Non-Hispanic/ Non-Latino/a Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Gender of Sex Partner(s): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender MtoF <input type="checkbox"/> Transgender FtoM <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Refused
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Infection(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: <input type="checkbox"/> Urine <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina <input type="checkbox"/> Urethra <input type="checkbox"/> Rectum <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Other: _____ Gonorrhea: <input type="checkbox"/> Urine <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina <input type="checkbox"/> Urethra <input type="checkbox"/> Rectum <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Other: _____	Specimen collection date: ____ - ____ - ____ Treatment date: ____ - ____ - ____ Allergic to: <input type="checkbox"/> Penicillin <input type="checkbox"/> Cephalosporins Medication(s) and Doses: <input type="checkbox"/> Not treated <input type="checkbox"/> Ceftriaxone 500mg IM <input type="checkbox"/> Ceftriaxone 1g IM <input type="checkbox"/> Azithromycin 1g po <input type="checkbox"/> Azithromycin 2g po <input type="checkbox"/> Doxycycline 100mg bid x 7d <input type="checkbox"/> Doxycycline 200mg q day x 7d <input type="checkbox"/> Cefixime 800mg po <input type="checkbox"/> Gentamicin 240 mg IM <input type="checkbox"/> Other med(s): _____	Chlamydia/ Gonorrhea Diagnosis <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic - uncomplicated <input type="checkbox"/> Eye infection <input type="checkbox"/> Disseminated gonorrhea <input type="checkbox"/> Lymphogranuloma venereum (LGV) <input type="checkbox"/> Other: _____
Partner Info.: Number Partners (last 60 days): _____		Number Treated (not including PDPT): _____
Number Given PDPT (Patient Delivered Partner Therapy): _____		

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Patient's Last Name	First Name	M.I.
Birth Date (mm/dd/yyyy)		
Provider Name	Provider Tel #	Provider Fax #

Syphilis


Syphilis stage <input type="checkbox"/> Primary (lesion/sore present) <input type="checkbox"/> Secondary (rash/condyloma lata present) <input type="checkbox"/> Early latent (≤1 year) <input type="checkbox"/> Late latent (>1 year) <input type="checkbox"/> Probable Congenital syphilis <input type="checkbox"/> Neurosyphilis	Symptoms/Signs <input type="checkbox"/> None <input type="checkbox"/> Genital ulcer <input type="checkbox"/> Rectal/perianal ulcer <input type="checkbox"/> Oral ulcer <input type="checkbox"/> Rash <input type="checkbox"/> Palmar/Plantar <input type="checkbox"/> Condyloma lata <input type="checkbox"/> Neurological symptoms <input type="checkbox"/> Ocular <input type="checkbox"/> Other: _____ Onset Date: ____ - ____ - ____
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Laboratory Name: _____ Blood test – collection date: ____ - ____ - ____ RPR <input type="checkbox"/> Neg <input type="checkbox"/> Pos: } Titer 1: _____ VDRL <input type="checkbox"/> Neg <input type="checkbox"/> Pos: } FTA-ABS <input type="checkbox"/> Neg <input type="checkbox"/> Pos TP-PA <input type="checkbox"/> Neg <input type="checkbox"/> Pos EIA/CIA <input type="checkbox"/> Neg <input type="checkbox"/> Pos Other (test name/result): _____ CSF – collection date: ____ - ____ - ____ CSF-VDRL <input type="checkbox"/> Neg <input type="checkbox"/> Pos: Titer 1: _____ CSF WBC _____ mm3 CSF protein _____ mg/dl	Infants only <input type="checkbox"/> Live birth <input type="checkbox"/> Still birth Gestation _____ weeks Weight _____ grams Long bone x-rays consistent <input type="checkbox"/> No <input type="checkbox"/> Unknown with congenital syphilis? <input type="checkbox"/> Yes <input type="checkbox"/> Not done Infant's serum RPR titer 4X mothers? <input type="checkbox"/> No <input type="checkbox"/> Yes Mothers only (complete only if this is baby's CMR) Syphilis stage: _____ Serology (at delivery) <input type="checkbox"/> RPR <input type="checkbox"/> VDRL <input type="checkbox"/> Titer 1: _____ Rx (meds & date/s): _____ Partner Information Number Partners _____ Number _____ (last 12 months): Treated:
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Patient Rx – Medication(s) and Doses: <input type="checkbox"/> Benzathine penicillin G 2.4MU IM once _____ <input type="checkbox"/> Benzathine penicillin G 2.4MU IM once _____ <input type="checkbox"/> Benzathine penicillin G 2.4MU IM once _____ <input type="checkbox"/> Doxycycline 100mg bid x 14 d <input type="checkbox"/> Doxycycline 100mg bid x 28 d <input type="checkbox"/> Other med(s): _____	Treatment date(s): _____ - _____ - _____ _____ - _____ - _____ _____ - _____ - _____ Treatment date(s): _____ - _____ - _____ _____ - _____ - _____	Allergic to: <input type="checkbox"/> Penicillin <input type="checkbox"/> Cephalosporins <input type="checkbox"/> Not treated
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Congenital Syphilis

Provide information 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	Birth Date (mm/dd/yyyy)	

REPORT TO:  Communicable Disease Program Phone: (805) 981-5201 Fax: (805) 981-5200 Email: vcph-id@ventura.org	FOR STI CMR FORMS: Visit and download the form at: https://vchca.org/for-health-care-providers-cmr-tb-forms For HIV reporting, call (805) 652-5780.
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