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
☐ 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

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:
☐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 500mg IM ☐Ceftriaxone 1g IM
☐Azithromycin 1g po
☐Azithromycin 2g po
☐Doxycycline 100mg bid x 7d ☐Doxycycline 200mg q day x 7d
☐Cefixime 800mg 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): _____

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.

Patient's Last Name	**First Name**	**M.I.**
Birth Date (mm/dd/yyyy)		
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): _____ ____ ____ - ____ ____ - ____ ____

_____ ____ ____ - ____ ____ - ____ ____

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:

VENTURA COUNTY PUBLIC HEALTH
A Department of Ventura County Health Care Agency

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) 652-3313.