LOS ANGELES COUNTY SEXUALLY TRANSMITTED DISEASE CONFIDENTIAL MORBIDITY REPORT

DATE OF REPORT (MMDDYY): __ __

REPORT STATUS: ☐ NEW ☐ UPDATE

REPORT DONE BY: (First+Space+Last)

1 PROVIDER

DIAGNOSING MEDICAL PRACTITIONER LAST NAME | FIRST NAME | TITLE ABBREVIATION

FACILITY/CLINIC NAME | SUITE/UNIT NO.

FACILITY/CLINIC STREET ADDRESS

CLINIC STAMP ▼

CITY/TOWN

STATE | OFFICE TEL. (Enter 999-999-9999 as 9999999999) __ __

ZIP CODE | OFFICE FAX (Enter 999-999-9999 as 9999999999) __ __

2 PATIENT INFORMATION

PATIENT'S LAST NAME | FIRST NAME | M.I.

MEDICAL RECORD NUMBER | AGE | BIRTHDAY (MMDDYYYY): __ __ | OCCUPATION

PATIENT STREET ADDRESS | APT/UNIT NO.

CITY/TOWN | STATE | ZIP CODE

HIV cases must be reported to **LA County HIV Epidemiology Program** (see section 5)

DAY TEL. (Enter 999-999-9999 as 9999999999) __ __ | EVENING TEL. (Enter 999-999-9999 as 9999999999) __ __

CELL PHONE (Enter 999-999-9999 as 9999999999) __ __ | E-MAIL ADDRESS

PREGNANT? ☐ Unknown ☐ No ☐ Yes ►If yes, date of LMP (MMDDYY): – –

If patient has HIV infection, have they received HIV partner servcies? ☐ Yes ☐ No ☐ Unknown

GENDER (X one):
☐ Male
☐ Female
☐ Transgender (M to F)
☐ Transgender (F to M)
☐ Unknown
☐ Other

MARITAL STATUS (X one):
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed
☐ Living with Partner

RACE (X all that apply):
☐ White
☐ Black or African American
☐ Native American or Alaska Native
☐ Asian or Asian American
☐ Native Hawaiian or Pacific Islander
☐ Unknown
☐ Other:

ETHICITY (X one):
☐ Hispanic or Latino
☐ Non-Hispanic/ Non-Latino

GENDER of SEX PARTNERS (X all that apply):
☐ Male
☐ Female
☐ Transgender (M to F)
☐ Transgender (F to M)
☐ Unknown
☐ Other
☐ Refused

3 DIAGNOSIS & TREATMENT

CHLAMYDIA (including PID)

DIAGNOSIS (X one):
☐ Asymptomatic
☐ Symptomatic - uncomplicated
☐ Pelvic Inflammatory Disease
☐ Opthalmia/Conjunctivitis
☐ Other:

SITE/SPECIMEN(S) (X all that apply):
☐ Urine
☐ Cervix
☐ Vagina
☐ Urethra
☐ Rectum
☐ Other:

Specimen Collection Date (MMDDYY): __ __

Treatment Date (MMDDYY): __ __ ☐ Not Treated

Medication & Dose:

Partner Information: Number Partners (last 60 days): | Number Treated (not including PDPT): | Number Given Patient Delivered Partner Therapy (PDPT)

GONORRHEA (including PID)

DIAGNOSIS (X one):
☐ Asymptomatic
☐ Symptomatic - uncomplicated
☐ Pelvic Inflammatory Disease
☐ Opthalmia/Conjunctivitis
☐ Disseminated
☐ Other:

SITE/SPECIMEN(S) (X all that apply):
☐ Urine
☐ Cervix
☐ Vagina
☐ Urethra
☐ Rectum
☐ Nasopharynx
☐ Other:

Specimen Collection Date (MMDDYY): __ __

Treatment Date (MMDDYY): __ __ ☐ Not Treated

Medications & Doses:

Partner Information: Number Partners (last 60 days): | Number Treated (not including PDPT): | Number Given Patient Delivered Partner Therapy (PDPT)

SYPHILIS, CONGENITAL SYPHILIS, OTHER REPORTABLE STDS AND REPORTING INFORMATION ON BACK PAGE.

PATIENT'S LAST NAME FIRST NAME M.I.

3 Cont.

DIAGNOSIS & TREATMENT

ADULT SYPHILIS

☐ Primary Syphilis Onset Date (MMDDYY): __ __

LESION SITES (X all that apply): ☐ Genital ☐ Rectum ☐ Oral ☐ Other: ☐ Vagina ☐ Perirectal

☐ Secondary Syphilis Onset Date (MMDDYY): __ __

SYMPTOMS (X all that apply): ☐ Palmar/Plantar Rash ☐ Other: ☐ General Body Rash ☐ Alopecia

☐ Early Latent (≤1 year)
☐ Late Latent (>1 year)
☐ Latent, Unknown Duration

☐ Late Syphilis
☐ Neurosyphilis } DESCRIBE SYMPTOMS

(The diagnosis of neurosyphilis must be accompanied by a staged diagnosis)

Specimen Collection Date (MMDDYY): __ __

Partner information: **Number elicited:** **Number treated:**

PREGNANT? ☐ Yes ☐ No ☐ Unknown

☐ RPR or ☐ VDRL } Titer: 1:

☐ TP-PA or ☐ FTA-ABS or ☐ Other } Reactive: ☐ Yes ☐ No

☐ CSF-VDRL Titer: 1:

Patient Treated: ☐ Yes ☐ No (If **yes,** give treatment/dose & dates below)

DATE(S) TREATED (MMDDYY) __ __ / __ __ / __ __

Medication & Dose:

CONGENITAL SYPHILIS (SEPARATE CMRS SHOULD BE SUBMITTED FOR MOTHER & INFANT)

INFANT INFORMATION

(Complete sections A & B if this is mother's CMR; Complete only B if this is infant's CMR)

A

INFANT'S LAST NAME

INFANT'S FIRST NAME

INFANT'S BIRTH DATE (MMDDYY) __ __

☐ Male ☐ Female ☐ Live Birth ☐ Still Birth

B

WEIGHT (grams)

SYMPTOMS (describe) ☐ No symptoms

GESTATION(wks)

Long Bone X-rays: ☐ Pos. ☐ Neg. ☐ Not Done

Serum RPR Lab Test Date (MMDDYY): __ __

☐ Reactive → Titer: 1:
☐ Non-Reactive
☐ Not Done

Titer 4x > mothers? ☐ Yes ☐ No

DATE INFANT TREATED (MMDDYY): __ __

CSF Laboratory Test Date (MMDDYY): __ __

VDRL: ☐ Non-Reactive ☐ Reactive

WBC>5/mm^3: ☐ Yes ☐ No

Protein>50mg/dl: ☐ Yes ☐ No

MEDICATION / DOSE

MATERNAL INFORMATION

(Complete if this is infant's CMR)

MOTHER'S LAST NAME

MOTHER'S FIRST NAME

MOTHER'S BIRTH DATE (MMDDYY) __ __

Lumbar Puncture Done: ☐ Yes ☐ No

MOTHER'S SEROLOGY AT DELIVERY
Lab Test Date (MMDDYY): __ __

☐ RPR or ☐ VDRL } Titer: 1:

☐ TP-PA or ☐ FTA-ABS or ☐ Other Reactive: ☐ Yes ☐ No

MOTHER'S STAGE OF SYPHILIS AT DIAGNOSIS
☐ Primary
☐ Secondary
☐ Early Latent (≤1 year)
☐ Late Latent (>1 year)
☐ Latent, Unknown Duration
☐ Late Syphilis

DATE(S) TREATED (MMDDYY) - - / - - / - -

MEDICATION / DOSE

OTHER REPORTABLE STDs

DIAGNOSIS	TREATED	DATE TREATED	MEDICATION / DOSE
☐ Pelvic Inflammatory Disease (complete if chlamydia & gonorrhea tests are negative or not available. If either test is positive, report in chlamydia and/or gonorrhea sections)	☐ Yes ☐ No	__ __	
☐ LGV	☐ Yes ☐ No	__ __	
☐ Chancroid	☐ Yes ☐ No	__ __	

4 SEND

FAX BOTH SIDES TO:
(213) 749-9602
OR
MAIL TO:
STD PROGRAM
2615 S. GRAND AVENUE, RM. 450
LOS ANGELES, CA 90007

5 INFO

FOR STD CMR FORMS:
Complete on-line or download from: http://publichealth.lacounty.gov/std/cmr.htm
or call (213) 741-8000 to request forms.

FOR INFORMATION AND QUESTIONS ABOUT STD REPORTING:
Visit http://publichealth.lacounty.gov/std/providers.htm or call (213) 744-3106.

FOR HIV REPORTING:
Visit http://publichealth.lacounty.gov/hiv/hivreporting.htm or call (213) 351-8516.