



LOS ANGELES COUNTY SEXUALLY TRANSMITTED DISEASE
CONFIDENTIAL MORBIDITY REPORT



DATE OF REPORT []-[]-[] REPORT STATUS: [] New [] Update REPORT DONE BY: []

1

PROVIDER

DIAGNOSING MEDICAL PRACTITIONER (LAST NAME & FIRST NAME)
TITLE ABBREVIATION
FACILITY/CLINIC NAME
SUITE/UNIT NO.
FACILITY/CLINIC STREET ADDRESS
CITY/TOWN
STATE OFFICE TEL.
ZIP CODE OFFICE FAX
CLINIC STAMP

2

PATIENT INFORMATION

PATIENT'S LAST NAME FIRST NAME M.I.
MEDICAL RECORD NUMBER SOCIAL SECURITY NUMBER OCCUPATION
PATIENT'S STREET ADDRESS APT/UNIT NO.
CITY/TOWN STATE ZIP CODE
DAY TEL. AGE: BIRTHDATE:
EVENING TEL. PREGNANT?
GENDER: MARITAL STATUS: RACE (X all that apply): ETHNICITY (X only one): GENDER of SEX PARTNERS:

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

3

DIAGNOSIS & TREATMENT

CHLAMYDIA (including PID)
DIAGNOSIS (X one):
SITE / SPECIMEN(S) (X all that apply):
Specimen Collection Date:
Treatment Date:
Medication & Dose:
Partner Information:

GONORRHEA (including PID)
DIAGNOSIS (X one):
SITE / SPECIMEN(S) (X all that apply):
Specimen Collection Date:
Treatment Date:
Medication & Dose:
Partner Information:

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



PATIENT'S LAST NAME (COMPLETE SECTIONS 1 & 2 FIRST)

FIRST NAME

M.I.

Grid for patient last name

Grid for patient first name

Grid for patient middle initial

ADULT SYPHILIS

Primary Syphilis: Onset Date, Lesion Sites (Genital, Rectum, Oral, Other, Vagina, Perirectal)

Secondary Syphilis: Onset Date, Symptoms (Palmar/Plantar Rash, General Body Rash, Alopecia, Other)

Latent Syphilis: Early Latent (<=1 Year), Late Latent (>1 Year), Latent, Unknown Duration, Late Syphilis, Neurosyphilis, Describe Symptoms

Specimen Collection Date, Partner Information (Number elicited, Number treated), Pregnant Partner?

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

DATE(S) TREATED, MEDICATION / DOSE

Specimen Titer: RPR or VDRL, TP-PA or FTA-ABS or Other, Reactive: Yes/No

CSF-VDRL Titer, DATE(S) TREATED, 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)

INFANT'S LAST NAME

INFANT'S FIRST NAME

INFANT'S BIRTH DATE, Male/Female, Live Birth/Still Birth

WEIGHT (grams), SYMPTOMS (describe), No symptoms

GESTATION (wks), Long Bone X-rays: Pos, Neg, Not Done

Serum RPR Lab. Test Date, CSF Laboratory Test Date

Reactive/Non-Reactive/Not Done, Titer: 1: (VDRL, WBC >5/mm³, Protein >50mg/dl)

Titer 4x> mothers? Yes/No, MEDICATION / DOSE

DATE INFANT TREATED

MATERNAL INFORMATION

(complete if this is infant's CMR)

MOTHER'S LAST NAME

MOTHER'S FIRST NAME

MOTHER'S BIRTH DATE, Lumbar Puncture Done: Yes/No

MOTHER'S SEROLOGY AT DELIVERY, Lab Test Date

MOTHER'S STAGE OF SYPHILIS AT DIAGNOSIS (Primary, Secondary, Early Latent, Late Latent, Latent, Unknown Duration, Late Syphilis)

RPR or VDRL, Titer: 1: (TP-PA or FTA-ABS or Other, Reactive: Yes/No)

DATE(S) TREATED, MEDICATION / DOSE

DATE(S) TREATED, MEDICATION / DOSE

DATE(S) TREATED, MEDICATION / DOSE

OTHER REPORTABLE STDs

DIAGNOSIS, TREATED, DATE TREATED, MEDICATION / DOSE (Pelvic Inflammatory Disease)

DIAGNOSIS, TREATED, DATE TREATED, MEDICATION / DOSE (LGV)

DIAGNOSIS, TREATED, DATE TREATED, MEDICATION / DOSE (Chancroid)

3 cont.

DIAGNOSIS & TREATMENT

A

B

4

SEND

5

INFO

FAX BOTH SIDES TO: (213) 749-9602

MAIL TO: STD PROGRAM, 2615 S. GRAND AVENUE, RM. 450, LOS ANGELES, CA 90007

FOR CMR FORMS & ENVELOPES: Call (213) 741-8000 or download CMR forms from http://publichealth.lacounty.gov/std/providers.htm

FOR CASE DEFINITIONS & REPORTING QUESTIONS: Call (213) 744-3106 or visit http://publichealth.lacounty.gov/std/providers.htm

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