

## LOS ANGELES COUNTY SEXUALLY TRANSMITTED DISEASE CONFIDENTIAL MORBIDITY REPORT

<b>K</b>	COUNTY OF LOS ANGELES Public Health
<b>y</b> -	

1/2	REPORT STATUS: Update DONE BY:							
	DIAGNOSING MEDICAL PRACTITIONER (LAST NAME & FIRST NAME)	TITLE ABBREVIATION						
(1	<u> </u>							
	FACILITY/CLINIC NAME	SUITE/UNIT NO.						
P R	FACILITY/CLINIC STREET ADDRESS							
o V		CLINIC STAMP						
	CITY/TOWN	,						
D E	STATE OFFICE TEL.							
R								
	ZIP CODE OFFICE FAX							
	PATIENT'S LAST NAME FIRST NAME	M.I.						
<b>(2</b> )								
$\bigcup$	MEDICAL RECORD NUMBER SOCIAL SECURITY NUMBER C	OCCUPATION						
	PATIENT'S STREET ADDRESS	APT/UNIT NO.						
PA								
T     <u>I</u>	CITY/TOWN STATE ZIP CODE	HIV cases must be						
E N	DAY TEL.  AGE: BIRTHDATE:	reported to						
T		LA County HIV Epidemiology Program						
I N	EVENING TEL. PREGNANT?	(see section 5)						
F O	( Unknown No Yes ► If yes, date of LMP:							
R M								
A	GENDER:       MARITAL STATUS:       RACE (X all that apply):       ETHNICITY (X only one):         ☐ Male       ☐ Single       ☐ White       ☐ Hispanic or Latino	GENDER of SEX PARTNERS:						
I,	Female Married Black or African American Non-Hispanic/	Female						
O N	☐ Transgender (M to F) ☐ Separated ☐ Native American or Alaska Native Non-Latino ☐ Transgender (F to M) ☐ Divorced ☐ Asian or Asian American	☐ Transgender (M to F) ☐ Transgender (F to M)						
	☐ Unknown ☐ Widowed ☐ Native Hawaiian or Pacific Islander	Other						
	☐ Other ☐ Living with Partner ☐ Unknown ☐ Other:	☐ Unknown ☐ Refused						
	CHLAMYDIA (including PID)							
	DIAGNOSIS (X one): SITE / SPECIMEN(S) (X all that apply)  Asymptomatic Urine Specimen Collection Date:	]-						
<b>(3</b>	Symptomatic - Cervix Treatment Date:	_ Not treated						
D	uncomplicated Vagina							
A	Disease Rectum & Dose:							
N O	Partner partners treated Partners	umber Given atient Delivered						
-AGNOS-S	Information: (last 60 days) (not including PDPT) (P	artner Therapy L						
& &	GONORRHEA (including PID)							
T	DIAGNOSIS (X one)  ☐ Asymptomatic  SITE / SPECIMEN(S) (X all that apply)  ☐ Urine  Specimen Collection Date:	J-						
l R l	Symptomatic - Cervix Treatment Date: - Vagina	_						
E A T	Pelvic Inflammatory Urethra Medication							
M	Opthalmia/Conjunctivitis Rectum	umber Given						
E N T	Disseminated Trasporary Partner Number treated P	atient Delivered artner Therapy						
	SYPHILIS, CONGENITAL SYPHILIS, OTHER REPORTABLE STDS AND REPORTING INFORMATION ON	BAUK PAGE.						

	PATIENT'S LAST NAME (COMPLETE SI	ECTIONS 1 & 2 FIRST)	FIRST NAME M	l.l.		
		ADULT S	YPHILIS			
	Primary Onset			$\overline{}$		
3 con	Syphilis Date:	LESION SIT (X all that apply)				
D	Secondary Onset Date:	SYMPTOMS (X all that apply)				
A	☐ Early Latent (<1 Year)	☐ Late Syphilis DESCRIE	BE			
G	Late Latent (>1 Year)	SYMPTO	DMS			
NO	☐ Latent, Unknown Duration	(The diagnosis of neurosyphilis must be ac	ccompanied by a staged diagnosis)			
S	Specimen Collection Date:					
S		PARTNER INFORMATION:	Number elicited: Number treated:			
&		Patient Treated: Yes N	No (If <b>yes</b> , give treatment/dose & dates below)			
	RPR or Titer:	DATE(S) TREATED	MEDICATION / DOSE	$\neg$		
T R	□ VDRL					
E	TP-PA or					
M	FTA-ABS or Reactive: Yes No			_		
E	CSF-VDRL Titer:					
T		CONGENITAL SYI	PHILIS (SEPARATE CMRS SHOULD BE SUBMITTED FOR MOTHER & INFAN	T )		
	INFANT INFOR	MATION	MATERNAL INFORMATION			
A	(complete sections A & B if this is mother's CMR;	Complete only B if this is infant's CMR)	(complete if this is infant's CMR)			
(	INFANT'S LAST NAME		MOTHER'S LAST NAME	$\neg$		
	INFANT'S FIRST NAME		MOTHER'S FIRST NAME	_		
		SENDER	MOTHER'S BIRTH DATE			
		_M _F	Lumbar Puncture Done: Yes	No		
(B	WEIGHT (grams) GESTATION (wks	S)	MOTHER'S SEROLOGY AT DELIVERY MOTHER'S STAGE OF			
$\sim$		✓ Live Birth Still Birth	Lab Test Date: SYPHILIS AT DIAGNOSIS			
	DESCRIBE		☐ Primary ☐ Secondary			
	SYMPTOMS:	□ None	RPR or ☐ Early Latent (<1 Year)			
	Long Bone X-rays: Positive Neg	gative Not Done	Late Later Helenen Borette	_		
	Serum RPR Lab. Test Date:	SF Laboratory Test Date:	☐ TP-PA or ☐ Latent, Unknown Duration☐ FTA-ABS or ☐ Reactive: ☐ Yes ☐ No ☐ Late Syphilis	a		
			Other			
	☐ Reactive → Titer:	'DRL:□Reactive □Non-reactive	DATE(S) TREATED MEDICATION / DOSE			
		VBC >5/mm³:				
	Not Done	Protein>50mg/dl: ☐Yes ☐No		_		
	Titer 4x> mothers? Yes No DATE INFANT TREATED ME	DICATION / DOSE				
	L L L L L L L L L L L L L L L L L L L	SIGATION / BOOL				
		OTHER REPO	RTABLE STDs			
DIAGNOSIS TREATED DATE TREATED MEDICATION / DOSE						
	Pelvic Yes No					
		ests are negative or not available. If either test i	s positive, report in chlamydia &/or gonorrhea sections)			
	☐ <b>LGV</b> ☐ Yes ☐ No					
				$\exists$		
	☐ Chancroid ☐ Yes ☐ No			<u></u>		
4	FAX BOTH SIDES TO: (213) 749		ST CMR FORMS & ENVELOPES: Call (213) 741-8000 or			
	or		at: www.lapublichealth.org/std/providers.htm			
S	MAIL TO: STD PROGRAM		DEFINITIONS & REPORTING QUESTIONS:			
N	2615 S. GRAND AVENUE, RM. 45	0   <b>F</b>   1   1   1   1   1   1   1   1   1	publichealth.org/std/providers.htm or call (213) 744-3106			
D	LOS ANGELES, CA 90007	O FOR HIV RE	PORTING:Call: (213) 351-8516 or visit www.lapublichealth.org/hi	iv		