



SURVEILLANCE MORBIDITY REPORT

HEALTH PROVIDER INFORMATION

REPORT DATE: _____

REPORTING FACILITY		LABORATORY USED	REQUESTING PHYSICIAN
TELEPHONE	FAX	REPORTING OFFICIAL	LOCATION OF HEALTH FACILITY

PATIENT DEMOGRAPHIC INFORMATION

LAST NAME			FIRST NAME		MEDICAL RECORD NUM	⇒ DATE OF BIRTH (mo/day/yr)	AGE
⇒ NUMBER AND STREET ADDRESS				APT. NUM.	⇒ CITY	⇒ STATE	⇒ ZIPCODE
Tel. () - Work/Cell () -			Emergency Contact			Tel. () -	
⇒ GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female		RACE: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other/Unknown <input type="checkbox"/> White					
MARITAL STATUS	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er) <input type="checkbox"/> Other	ETHNICITY: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			Is Patient Pregnant? <input type="checkbox"/> Yes ___# Wks <input type="checkbox"/> No		

PATIENT MEDICAL HISTORY

⇒ REASON FOR EXAM: (Chief Complaint, Type of visit , ER, Delivery)		_____					
⇒ DIAGNOSIS		<input type="checkbox"/> GONORRHEA <input type="checkbox"/> CHLAMYDIA <input type="checkbox"/> HERPES <input type="checkbox"/> SYPHILIS <input type="checkbox"/> OTHER: _____ Syphilis Stage - <input type="checkbox"/> Primary (Lesion) <input type="checkbox"/> Secondary (Rash) <input type="checkbox"/> Early Latent (< 1yr) <input type="checkbox"/> Congenital <input type="checkbox"/> Other:					
⇒ SYMPTOMS		Date of Onset	Duration: days	Unknown	Was patient counseled about partner notification? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		

⇒ LABORATORY TEST - Specify Lab Test (Smear, Culture, Urine, DNA Probe, Darkfield, RPR or VDRL, MHA-TP, FTA-ABS, FTA-IgM)

DATE OF TEST	TYPE OF TEST	RESULT

⇒ TREATMENT (List current infection treatment below):

DATE OF TREATMENT	MEDICATION/DRUG	DOSAGE

COMMENTS: _____ _____	Is this a non-compliant patient? ___ Yes ___ No If yes, complete emergency contact information listed above.
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INSTRUCTIONS: As a minimum, reports MUST include information marked with an "arrow" ⇒ symbol. STD reporting requirements are listed in the DC Municipality Regulation, Public Health & Medicine. Upon completion, the information contained in this form must be treated in accordance with Confidentiality Laws. Reports are to be faxed to the Surveillance Unit, Division of STD Control at Fax Number: 202-727-4934. If mailed, reports should be sent to: **Surveillance Unit, STD Control Program, 825 North Capitol St, N.E., 2nd Fl., Washington, D.C. 20002.** Questions regarding reporting criteria and requirements should be addressed to Surveillance Unit at Tel 202-727-9860/6408.