



To request **Partner Notification Services** for your patient, please call the Division of STD Prevention at **(617) 983-6940**

SYPHILIS

For assistance filling out this form, call (617) 983-6940

CASE REPORT FORM

Version 7/9/2013

PATIENT INFORMATION

Last Name: _____ First Name: _____ DOB: ___/___/___ Med Rec #: _____
 Middle Initial: _____ Social Security #: _____

Street Address: _____ Homeless Incarcerated
 Gender: Male Female Transgender Unknown

City: _____ Zip: _____ Ethnicity: Hispanic/Latino Non-Hispanic Latino Unknown

Cell Phone #: _____ Home Phone #: _____ Race: (check all that apply)
 White Black Asian
 Native Hawaiian/Pacific Islander American Indian/Alaskan Native
 Other(specify): _____ Unknown

Primary Language Spoken: English Other(specify): _____ Pregnant? Yes No Unknown Not applicable

Diagnosis Date: ___/___/___ Did the patient have any symptoms? Yes No Unknown

If symptomatic, what stage of syphilis was patient diagnosed at? (check all that apply): <input type="checkbox"/> Primary syphilis <input type="checkbox"/> Secondary syphilis <input type="checkbox"/> Neurosyphilis <input type="checkbox"/> Other(specify): _____	If asymptomatic, what stage of syphilis was patient diagnosed at? (check all that apply): <input type="checkbox"/> Early latent syphilis (infection acquired < 1 yr ago) <input type="checkbox"/> Late latent syphilis (infection acquired ≥ 1 yr ago) <input type="checkbox"/> Latent syphilis of unknown duration <input type="checkbox"/> Other(specify): _____	If asymptomatic, why was the patient tested? (check all that apply): <input type="checkbox"/> Reported contact to syphilis case <input type="checkbox"/> Screening <input type="checkbox"/> Rescreening after previous positive <input type="checkbox"/> Patient request <input type="checkbox"/> Other(specify)
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Does the patient have sex with: Men Women Both Unknown
 Has the patient exchanged money for sex and/or drugs? Yes No Unknown
 Has the patient had sex while intoxicated and/or high? Yes No Unknown
 Has the patient travelled out of the state in the last year? Yes (specify): _____ No Unknown
 Has the patient been incarcerated in the last six months? Yes No Unknown
 Other risk factors: _____

Treatment Date: ___/___/___ Other treatment (specify): _____ Not treated
 Benzathine penicillin G 2.4 million units IM-- 1 dose (for primary, secondary, early latent syphilis)
 Benzathine penicillin G 2.4 million units IM - 3 doses, 1 week apart (for late latent, or latent syphilis of unknown duration)
 Aqueous crystalline penicillin G 3-4 million units IV every 4 hours or continuous infusion for 10-14 days (for neurosyphilis)

TESTING AGENCY INFORMATION

Provider Name: _____ Facility: _____ Phone #: _____
 Address: _____ City: _____ Zip: _____ Fax: _____

Testing Setting: Other(specify): _____
 Drug Treatment Facility Private Practice or HMO ER or Urgent Care
 HIV Counseling, Testing, and Referral Site Community Health Center School-based Clinic including College/University
 Blood Bank Hospital-based Clinic Military/VA/Job Corps Clinic
 Mental Health Services Site STD, HIV or Family Planning Clinic Correctional Institution

TREATING CLINICIAN INFORMATION (If different from testing agency): Same as testing agency

Clinician Name: _____ Facility: _____ Phone #: _____
 Address: _____ City: _____ Zip: _____ Fax: _____

Clinician Practice Setting:
 Private Practice or HMO STD, HIV, or Family Planning Clinic Military/VA/Job Corps Clinic
 Community Health Center ER or Urgent Care Correctional Institution
 Hospital-based Clinic School-based Clinic including College/University Other(specify): _____

ADMINISTRATIVE INFORMATION

Date Form Completed: ___/___/___ Same as treating clinician
 Name/Contact Information of person completing report (if not treating clinician): _____