



Delaware Confidential Morbidity Report—Sexually Transmitted Diseases

Patient Name (Last, First, MI)	SSN	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
	Phone	Date of Birth / /	

Patient Address	City	State	Zip	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Prev 12 months
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Race <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaskan Native	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Civil Union <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other <input type="checkbox"/> Unknown
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Laboratory Tests (1)
N. gonorrhoea

Confirmed Positive
by _____

Presumptive Positive
Beta Lactamase Positive
Negative

Date _____

C. trachomatis

Confirmed Positive
by _____

Date _____

Syphilis

RPR Reactive _____dls
 Non-reactive

VDRL Reactive _____dls

TP-PA Reactive
 Non-reactive

FTA-ABS Reactive
 Non-reactive

Other _____

Date _____

Reported by: (3)

Laboratory Name Phone

Address

Date Reported _____

Green Copy - STD Program
Yellow Copy - File
White Copy - Provider

Diagnosis (2) Syphilis (check only one)

Primary
 Secondary
 Early latent (<1 year)
 Late latent (>1 year)
 Congenital (See Cong. Section)
 Neurosyphilis

Chlamydia (check all that apply)

Asymptomatic
 Symptomatic
 Pelvic Inflammatory Disease
 Conjunctivitis
 Other _____

Site

Cervix
 Urethra
 Other _____

Gonorrhea (check all that apply)

Asymptomatic
 Symptomatic
 Pelvic Inflammatory Disease
 Disseminated
 Conjunctivitis
 Antibiotic resistant
 Other _____

Site

Cervix
 Urethra
 Rectum
 Pharynx
 Other _____

Other STDS (check all that apply)

NGU
 Herpes
 Chancroid
 Mucopurulent Cervicitis
 HIV
 Granuloma inguinale
 Human Papilloma Virus
 Lymphogranuloma Venereum
 Other (specify) _____

Congenital Syphilis (4)**Infant Information**

- Live Birth Weight in grams _____
- Still birth Born alive, then died Date_____
- Estimated gestation age (weeks) _____
- Darkfield Positive
- Long Bones X-rays Positive Negative
- CFS VDRL Reactive Non-reactive
- WBC >5/mm³ Yes No
- Protein >50 mg/dl Yes No
- Hepatosplenomegaly
- Cutaneous lesions
- Snuffles
- Asymptomatic
- Other _____

Maternal Information

- Mother's Name _____
- Medical Record Number _____
- Mother's Birth Date _____
- Mother's Race** White Black
 American Indian/Alaskan Native
 Asian/Pacific Islander
- Ethnicity** Hispanic Non-Hispanic
- Mother's Diagnosis _____
 (Stage)
- by _____
 (Physician)
- Prenatal Care _____/_____/_____
 (Date First Visit)
- Total visits _____
- No Prenatal Care**

Mother's Serology History

	Date	Titer		Date	Result
RPR			FTA		
RPR			TP-PA		
RPR					

Treatment (5) Based upon Diagnosis section 2 Date ____/____/____

- 2.4 mu Benzathine Pen G Ciprofloxacin 500 mg
- 7.2 mu Benzathine Pen G Azithromycin 1 gm
- Ceftriaxone Sodium Doxycycline 100 mg BID X
- 125 mg 250 mg 7 days 14 days (Other) _____ days
- Other Treatment and Dosage _____

Reported by (6) Date ____/____/____

Name _____

Facility _____

Address _____

City _____

State _____ Zip _____

Phone _____

Please mail completed pages of this form to: The Division of Public Health STD Program Office at 417 Federal Street, Dover, DE 19901. If you need to contact us with questions or request a copy of the DPH reporting regulations please call at (302) 744-1025 or visit our web site at <http://www.dhss.delaware.gov/dhss/dph/dpc/stds.html>