# **Delaware Confidential Morbidity Report–**Sexually Transmitted Diseases

**Patient Name (Last, First, MI)**

**SSN**

**Age**

**Sex** ☐ M ☐ F

**Phone**

**Date of Birth** / /

**Patient Address** **City** **State** **Zip**

**Pregnant**
☐ Yes ☐ No
☐ Unknown
☐ Previous 12 months

**Race**
☐ White ☐ Black ☐ Asian
☐ American Indian/Alaskan Native
☐ Native Hawaiian or Pacific Islander
☐ Unknown

**Ethnicity**
☐ Hispanic
☐ Non-Hispanic

**Marital Status**
☐ Married ☐ Civil Union
☐ Single ☐ Divorced
☐ Other ☐ Unknown

**Sex Partner**
☐ Male ☐ Female

## Laboratory Tests

### *N. gonorrhea*

☐ Confirmed Positive
by ___________________________________
☐ Presumptive Positive
Beta Lactamase Positive ☐
Negative ☐

Date___________________________________

### *Chlamydia 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:

___________________________________
Laboratory Name Phone

___________________________________
Address

___________________________________

Date Reported __________________________

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

## Diagnosis Syphilis (check only one)

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

## Chlamydia (check all that apply)

☐ Asymptomatic
☐ Symptomatic
☐ Pelvic Inflammatory Disease
☐ Conjunctivitis
☐ Other ______________________________

**Site**
☐ Cervix
☐ Urethra
☐ Rectum
☐ Pharynx
☐ 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

### 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

CSF 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 ☐ Asian ☐ Multiple Races
☐ American Indian/Alaskan Native
☐ Native Hawaiian or 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 Based upon Diagnosis

**Date**_____/______/______

☐ 2.4 mu Benzathine Pen G(Bicillin)

☐ 7.2 mu Benzathine Pen G(Bicillin)

☐ Cefixime (Suprax) 400 mg

☐ Metronidazole 500 mg BID X

☐ 7 days ☐ 10 days ☐ 14 days

☐ (Other) ______days

☐ Ceftriaxone Sodium (Rocephin)

☐ 250 mg ☐ 500 mg

☐ Azithromycin 1 gm ☐ Azithromycin 2 gm

☐ Doxycycline 100 mg BID X

☐ 7 days ☐ 14 days ☐ (Other) ______days

Other Treatment and Dosage

______________________________

### Reported by

**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 or fax to 302-857-5086. 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