DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Delaware Confidential Morbidity Report–Sexually Transmitted Infections (STI)

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 _____

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 STIs (check all that apply)

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

Reported by:

_____
Laboratory Name Phone

_____
Address

_____

Date Reported _____

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

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			Write In:		

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 302-661-7200. If you need to contact us with questions or request a copy of the DPH reporting regulations please call at (302) 744-1044 or visit our web site at http://www.dhss.delaware.gov/dhss/dph/dpc/stds.html