MINNESOTA CONFIDENTIAL SYPHILIS REPORT FORM

PATIENT INFORMATION

Patient last name:

Medical record number:

Patient first name:

M.I.:

E-mail:

Patient street address:

Apt/unit #:

City/town:

State:

Zip:

☐ Homeless

☐ Address unknown

Home phone:

Mobile/cell phone:

Work phone:

Date of birth: (MM-DD-YYYY)

____/____/________

Gender: (mark one only)
- ○ Male
- ○ Female
- ○ Transgender (M to F)
- ○ Transgender (F to M)

Pregnant:
- ○ No
- ○ Unknown
- ○ Yes

weeks:

Due date: (MM-DD-YY)

____/____/________

Race: (mark all that apply)
- ☐ American Indian/Alaska Native
- ☐ Asian/Asian American
- ☐ Black/African American
- ☐ Native Hawaiian/ Other Pacific Islander
- ☐ White
- ☐ Other:________
- ☐ Unknown

Ethnicity: (mark one only)
- ○ Hispanic/Latino
- ○ Non-Hispanic/Non-Latino
- ○ Unknown

Country of birth:
- ○ United States
- ○ Other:________
- ○ Unknown

HIV tested at this visit:
- ○ Yes
  - Result:
  - ○ Positive ○ Negative
- ○ No
- ○ Previous positive

Patient on PrEP?
- ○ Yes
- ○ No

Patient informed of syphilis results:
- ○ Yes
- ○ No
- ○ Unknown

Patient previously tested for syphilis:
- ○ Yes
  - Latest date: (MM-DD-YY)
  - ____/____/________
  - Result:________
- ○ No

PARTNER INFORMATION

Partner gender(s): (mark all that apply)
- ☐ Male
- ☐ Female
- ☐ Transgender (M-F)
- ☐ Transgender (F-M)
- ☐ Unknown

partners (last 60 days):

Provide name(s) and locating information for any untreated partners if you would like MDH assistance with partner notification. This information is private and NO information that could identify your patient will be revealed to partners. In most cases, partner follow-up cannot be initiated unless specific locating information is given below. If partners are not informed and treated, reinfection of the patient may occur. For information about MDH's Partner Services Program and information on Expedited Partner Therapy (EPT) / Patient Delivered Therapy, see http://www.health.state.mn.us/std

Additional partner information: (name, address, city, state, zip, phone number(s), e-mail address, screen name, race/ethnicity, sex, age, date of birth, date of last exposure, physical description, additional information)

PROVIDER INFORMATION

Diagnosed by:

Reported by (if different from diagnosed by):

Facility/clinic name:

Office telephone:

Facility/clinic address:

Office fax:

City:

State:

Zip:

Report diagnosis and treatment on page 2.

When complete fax to: 1-800-298-3775

MINNESOTA CONFIDENTIAL SYPHILIS REPORT FORM, PAGE 2

Patient last name:

Medical record number:

SPECIMEN COLLECTION

Specimen collection: (MM-DD-YY)

____/____/________

Reason for test: (mark all that apply)

- ☐ Signs/symptoms
- ☐ Screening
- ☐ Pregnant
- ☐ Exposure
- ☐ Other:

Non-Treponemal

- ☐ USR or
- ☐ RPR or
- ☐ VDRL

Reactive: ☐ Yes ☐ No

Titer: 1:

Treponemal

- ☐ TP-PA or
- ☐ FTA-ABS or
- ☐ Trep EIA

Reactive: ☐ Yes ☐ No

CSF-VDRL

Reactive: ☐ Yes ☐ No

Titer: 1:

Other

Reactive: ☐ Yes ☐ No

Titer: 1:

DIAGNOSIS & TREATMENT

EARLY

☐ Primary Syphilis - lesion present

Lesion site(s):

Onset date: (MM-DD-YY)

____/____/________

☐ Secondary Syphilis - symptoms present

Symptom type:

Onset date: (MM-DD-YY)

____/____/________

☐ Early Latent (≤1 year) - In past year: negative syphilis test, or early syphilis symptoms, or documented contact with early syphilis

Date of negative test: (MM-DD-YY)

____/____/________

Treatment type:

- ○ Benzathine penicillin G: 2.4 million units IM in a single dose
- ○ Doxycycline: 100 mg po BID x 14 days
- ○ Not Treated for Syphilis
- ○ Other:

Treatment date: (MM-DD-YY)

____/____/________

LATE

☐ **Unknown Duration or Late Latent (>1 year)** - No signs/symptoms, or no documented exposure to early syphilis, or no negative test result in past year.

Treatment type:

- ○ Benzathine penicillin G: 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals
- ○ Doxycycline: 100 mg po BID x 28 days
- ○ Not Treated for Syphilis
- ○ Other:

Treatment dates: (MM-DD-YY)

____/____/________

____/____/________

____/____/________

OTHER

☐ Neurosyphilis - Must be accompanied by a staged diagnosis. Symptoms:

☐ Occular Syphilis - Symptoms:

Onset date: (MM-DD-YY)

____/____/________

Treatment type:

- ○ Aqueous crystalline penicillin G: 18–24 million units per day, administered as 3–4 million units IV every 4 hours or continuous infusion, for 10–14 days

Treatment date: (MM-DD-YY)

____/____/________

MINNESOTA CONFIDENTIAL SYPHILIS REPORT FORM INSTRUCTIONS

- Health care providers should use this form to report lab confirmed cases of STDs as mandated by State law (Minnesota Rule 4605.7040).
- All case reports are classified as private under the Minnesota Government Data Practices Act.
- Laboratory reports do not substitute for physician case reports.
- Report only lab confirmed cases.
- TYPE or PRINT clearly in CAPITAL LETTERS using black ink.
- If completing the form by hand, complete choice boxes with an “X.”
- Do not affix labels to this form.

- For more report forms visit: http://www.health.state.mn.us/diseasereport/
- To report Congenital Syphilis or Chancroid call: 651-201-5414

Return completed form by:

- **Fax:** 1-800-298-3775 or
- **Mail:** MDH STD/HIV/TB Section P.O. Box 64975 St. Paul, MN 55164-0975

Minnesota Department of Health, STD/HIV/TB Section
PO Box 64975
St. Paul, MN 55164-0975
Phone: 651-201-5414 | Fax: 1-800-298-3775