Date Received by WCDOH: _____

WESTCHESTER COUNTY DEPARTMENT OF HEALTH
STD CLINICAL CASE REPORTING FORM

Please complete and fax this form within 2 working days to WCDH at 914-813-5189 on all patients suspected or diagnosed with syphilis, gonorrhea, or *Chlamydia* as mandated by New York State Public Health Law, Article 21, and New York State Sanitary code (10NYCRR 2.10,2.14).

BULLETED ITEMS MUST BE CALLED WITHIN ONE WORKING DAY TO WCDH AT 914-813-5115

- **All pregnant females with syphilis, gonorrhea, or *Chlamydia***
- **All positive syphilis non-treponemal delivery serologies regardless of titer or positive confirmatory treponemal testing**
- **All syphilis non-treponemal test results of ≥1:16**
- **All patients clinically suspected or diagnosed with primary or secondary syphilis**

Patient Name: _____ **Alias:** _____

Address:_____ **City/Town**_____**State**____**Zip**____

Telephone Number(s): Cell: _____ **Home:** _____ **Other:**_____

Date of Birth: _____ **Sex:** ◯**M** ◯**F**

Race: ☐**Black** ☐**White** ☐**Asian Amer.** ☐**Indian/Alaskan** ☐ **Hawaiian/Pacific Islander** ☐**Other/Unk**

Ethnicity: ◯**Hispanic** ◯**Non-Hispanic** ◯**Unknown**

Is patient pregnant? ☐**No** ☐**Yes** **If yes, what is her due date?** _____

Why was test performed? ☐ **Symptoms** ☐ **Prenatal** ☐**Patient Referral** ☐**Routine Screening**

Date of specimen collection: _____ **Date of first symptom(s):** _____

Please list symptoms, if any: _____

DIAGNOSIS: ☐**Syphilis** ☐**Gonorrhea** ☐***Chlamydia***

TREATMENT: (Date) _____ **(Medication)** _____ **(Dose/Frequency):**_____

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For Patients with Syphilis:

Syphilis Stage: ◯**Primary** ◯**Secondary** ◯**Early Latent** ◯**Late Latent (of unknown duration)**

RPR: Titer _____ **Confirmatory Test:** ☐**TPPA** ☐**MHA-TP** ☐**FTA- Result** _____

☐**Prior Syphilis Test /Results** ☐**No Prior Syphilis Test**

RPR (Date/Titer): _____**Confirmatory Test:**☐ **TPPA** ☐**MHA** ☐**FTA- Result**_____

Previous Syphilis Treatment: (Date) _____ **(Medication)** _____ **(Dose/Frequency)** _____

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PLEASE DO NOT REPORT ANY HIV RESULTS ON THIS FORM

HIV Testing Done: ◯ **Yes / Date:** _____ ◯ **No** **Date Planned:** _____

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Has treating provider notified patient of Dx or to return for Rx? ☐**Yes** ☐**No Date:** _____

If patient hasn't been treated do you need WCDH assistance in contacting the patient? ☐**Yes**☐**No**

Expedited Partner Therapy (EPT) provided for *Chlamydia* patient? ☐ **Yes** ☐ **No**

# of partners provided EPT ____

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Name of healthcare facility or practice: _____ **Address:** _____

Ordering Clinician: _____**Ordering Clinician telephone#**_____

Person completing report: Print Name _____

Signature_____

Date Completed _____

Telephone#_____Ext:_____Fax#_____

Created 3/20/2012
Revised 05/2023

Clear Form