Clear Form

33388

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
ILLINOIS CONFIDENTIAL MORBIDITY REPORT OF SEXUALLY TRANSMITTED INFECTIONS

PATIENT INFORMATION

FIRST NAME | M.I.

LAST NAME | IDOC #

Expedited Partner Therapy (EPT) given to patient with CHLAMYDIA and/or GONORRHEA for partner(s).
○ Yes ○ No ○ Unknown
If yes, for how many partners?

STREET ADDRESS

APARTMENT NUMBER | CITY | STATE (I L)

ZIP CODE | COUNTY OF RESIDENCE | PHONE NUMBER (- -)

DATE OF BIRTH (/ /)

RACE (Select All That Apply)
○ White ○ Black or African American ○ Asian ○ American Indian or Alaskan Native ○ Native Hawaiian or Other Pacific Islander ○ Other ○ Unknown

ETHNICITY
○ Hispanic or Latinx ○ Not Hispanic or not Latinx ○ Unknown

SEX AT BIRTH
○ Male ○ Female ○ Unknown

CURRENT GENDER
○ Male ○ Female ○ Something Else ○ Transgender Male (FTM)* ○ Transgender Female (MTF)* ○ Transgender Unknown ○ Unknown

SEX OF SEX PARTNER(S) (Select All that Apply)
○ Male ○ Female ○ Something Else ○ Transgender Male (FTM)* ○ Transgender Female (MTF)* ○ Transgender Unknown ○ Unknown

PREGNANT ○ Yes ○ No
EST. DUE DATE (/ /)

DIAGNOSIS

Chlamydia
○ Genito-urinary ○ Rectal ○ Ophthalmia ○ PID* ○ Pneumonia ○ LGV* ○ Other: _____

Gonorrhea
○ Genito-urinary ○ Rectal ○ Ophthalmia ○ DGI* ○ Pharyngeal ○ PID* ○ Other: _____

Other STIs
○ Chancroid
DATE OF TEST/EXAM (/ /)

Syphilis Stage
○ Primary ○ Secondary ○ Early, NPNS* ○ Late or Unknown ○ Congenital

Syphilis Symptoms
○ Lesion/Chancre ○ None ○ Rash (P/P* or GBR*) ○ Neurologic: _____ ○ Ocular: _____ ○ Otic: _____ ○ Other: _____

LABORATORY TEST(S) RELATED TO DIAGNOSIS

Chlamydia Test
DATE POSITIVE TEST COLLECTED (/ /)

Gonorrhea Test
DATE POSITIVE TEST COLLECTED (/ /)

Syphilis Tests

Serologic Screening Test: RPR, VDRL
DATE OF TEST (/ /) RESULT ○ Pos ○ Neg
Titer 1: ____

Serologic Confirmatory Test: FTA-ABS, TP-PA, EIA
DATE OF TEST (/ /) RESULT ○ Pos ○ Neg

Darkfield / DFA-TP or PCR (from lesion)
DATE OF TEST (/ /) RESULT ○ Pos ○ Neg

CSF-VDRL
DATE OF TEST (/ /) RESULT ○ Pos ○ Neg

TREATMENT (RX) INFORMATION (See reverse side for treatment codes)

Date(s) Treated	RX Codes	Other
/ /		
/ /		
/ /		

Syphilis Neurologic Involvement ○ Verified (Positive CSF-VDRL) ○ Possible

FACILITY WHERE SPECIMEN WAS COLLECTED

Name _____
Address _____
City _____ Phone _____

FACILITY WHERE PATIENT WAS TREATED

Name _____
Address _____
City _____ Phone _____
Name of Person Completing Form _____

If you need assistance in sex partner referral, need additional forms, etc., call your local health department STI program.

Submit this report to your local health department:

If NO local health department, contact:
Illinois Department of Public Health
ATTN: STI Section
525 W. Jefferson St., Ground Floor
Springfield, IL 62761
Phone: 217-782-2747

Updated 2022

Patient Last Name, First Name

Date of Birth

Additional Critical Syphilis Information to Collect from Patient

1. What was the reason for testing the patient for syphilis?

2. What signs/symptoms of syphilis were noted on or by the patient or provider? When did they manifest?

3. Please provide any information about sex partners of the patient.

4. Does the patient have any previous history of syphilis?

5. If the patient is female, is the patient pregnant? How many weeks? What is the estimated due date?

6. Any other additional information:

Use the Rx codes below for completing the treatment information on the reverse side.

Rx Code	CHLAMYDIA
210	**AZITHROMYCIN 1 GM**
215	**DOXYCYCLINE 100 MG BID X 7 DAYS**
220	DOXYCYCLINE 100 MG BID X 14 DAYS
225	DOXYCYCLINE 100 MG BID X 10 DAYS
205	AMOXICILLIN 500 MG TID X 7 DAYS
245	ERYTHROMYCIN BASE 250 MG QID X 14 DAYS
255	ERYTHROMYCIN BASE 500 MG QID X 7 DAYS
265	OFLOXACIN 300 MG BID X 7 DAYS
285	LEVOFLOXACIN 500 MG DAILY X 7 DAYS
256	PEDIATRIC TREATMENT *(Please indicate drug, dose, and regimen under "Other")*
600	IV THERAPY *(Please indicate drug, dose, and regimen under "Other")*

Note: If dual therapy was administered, enter the appropriate Rx Code listed under Gonorrhea.

Rx Code	GONORRHEA (DUAL THERAPY[1])
325	**CEFTRIAXONE 500 MG**
330	**CEFIXIME 800 MG**
125	GEMIFLOXACIN 320 MG PLUS AZITHROMYCIN 2 GM
130	GENTAMICIN 240 MG PLUS AZITHROMYCIN 2 GM
120	*CEFTRIAXONE 500 MG PLUS DOXYCYCLINE 100 MG BID X 7 DAYS*[2]
105	*CEFIXIME 800 MG PLUS DOXYCYCLINE 100 MG BID X 7 DAYS*[2]
357	PEDIATRIC TREATMENT *(Please indicate drug, dose, and regimen under "Other")*
600	IV THERAPY *(Please indicate drug, dose, and regimen under "Other")*

Rx Code	SYPHILIS	Rx Code	SYPHILIS
705	BENZATHINE PENICILLIN G 2.4 MU	**770**	AQ. CRYST. PCN IV X 10-14 DAYS
725	BENZATHINE PENICILLIN G 2.4 MU X 3 WEEKS	**775**	DOXYCYCLINE 100 MG BID X 14 DAYS
755	BENZATHINE PENICILLIN G PEDIATRIC	**780**	DOXYCYCLINE 100 MG BID X 28 DAYS
765	PROCAINE PENICILLIN G IM X 10-14 DAYS		

Rx Code	CHANCROID	Rx Code	LYMPHOGRANULOMA VENEREUM (LGV)
400	AZITHROMYCIN 1 GM	**500**	DOXYCYCLINE 100 MG BID X 21 DAYS
405	CEFTRIAXONE 250 MG	**505**	ERYTHROMYCIN BASE 500 MG QID X 21 DAYS
410	CIPROFLOXACIN 500 MG BID X 3 DAYS	510	AZITHROMYCIN 1 GM WEEKLY X 3 WEEKS
415	ERYTHROMYCIN BASE 500 MG TID X 7 DAYS		

Rx Code	MISCELLANEOUS CODES
000	NO TREATMENT (Applies to All Diagnoses)
800	OTHER ADEQUATE TREATMENT *(Please indicate drug, dose, and regimen under "Other")*

[1] Administration of two medications.

[2] If chlamydial infection has not been excluded, treat for chlamydia with doxycycline 100 mg orally 2 times/day for 7 days.

*Abbreviations:

MTF-Male to Female **FTM**-Female to Male **PID**-Pelvic Inflammatory Disease **DGI**-Disseminated Gonoccocal Infection **LGV**-Lymphogranuloma venereum **NPNS**-non-primary, non-secondary **P/P**-Plantar/Palmar **GBR**-Generalized Body Rash

For more details on the CDC STD Treatment Guidelines or information on STDs, visit: **www.cdc.gov/std**.

The Illinois Department of Public Health is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under Illinois Sexually Transmissible Disease Control Act (410 ILCS 325, ch. 111 ½, par. 7401 et seq). Disclosure of this information is MANDATORY.

Updated 2022