Fax Report to the STD Confidential Fax Line: (609) 826-4870

The State of New Jersey Department of Health
Sexually Transmitted Disease Program
SYPHILIS CASE REPORT FORM
PO Box 363, Trenton NJ 08625-0363 | 609-826-4869

****Lab Report MUST be faxed with this Case Report Form***

Questions colored in red are required fields. Please ensure all required fields are complete before submitting this form.

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE (indicate home, work or cell)	SEX AT BIRTH	CURRENT GENDER	IS PATIENT PREGNANT?	ESTIMATED DELIVERY DATE (n/a if not pregnant):
	☐Male ☐Female	☐Male ☐Female	☐Yes ☐No ☐Unknown	

ETHNICITY
☐Hispanic
☐Non-Hispanic
☐Unknown

RACE (Check all that apply)
☐White ☐Black ☐Asian
☐American Indian/Alaskan Native
☐Native Hawaiian/Other Pacific Islander
☐Unknown

GENDER OF SEX PARTNER(S)
☐Male
☐Female
☐Both
☐Unknown
☐Other: _____

REASON FOR EXAM (Check one)
☐Symptomatic (describe below)
☐Routine exam – no symptoms
☐Exposed to infection

DATE OF LAST HIV TEST:

RESULT: ☐Pos ☐Neg ☐Unk

IS PATIENT ON PrEP?
☐Yes ☐No ☐Unknown

WAS PATIENT REFERRED TO PrEP?
☐Yes ☐No ☐Unknown

DIAGNOSIS

SYPHILIS

DIAGNOSIS (select one):
☐Primary (chancre)
☐Secondary (rash, etc.)
☐Early latent (<1 year duration but no symptoms)
☐Late latent (>1 year duration but no symptoms)
☐Unknown duration
☐Congenital

ADDITIONAL DIAGNOSES (check all that apply):
☐Neuro syphilis ☐Ocular syphilis ☐Otic syphilis

LAB RESULTS: (*MUST include lab report with this form*)

TREATMENT:
DATE TREATED: _____ (check all treatments below that apply)
☐Bicillin 2.4mu IMx1 ☐Bicillin 2.4mu IMx3wks
☐Other (include dosage):_____

SYMPTOMS:
SYMPTOM ONSET DATE (n/a if not pregnant) :
DESCRIBE SYMPTOMS (Check all that apply):
☐ Chancre/Lesion ☐ Palmar Rash ☐ Plantar Rash ☐ Other Rash:
☐ Alopecia ☐ Other:

PATIENT SYPHILIS HISTORY:
BEFORE THESE POSITIVE RESULTS, WAS THE PATIENT EVER PREVIOUSLY TESTED FOR SYPHILIS?
☐ Yes ☐ No ☐ Unknown
IF YES:
DATE OF PREVIOUS RPR:_____ RESULT: ☐Positive ☐Negative TITER:_____
DATE OF PREVIOUS TREPONEMAL: _____ RESULT: ☐Positive ☐Negative

COMMENTS:

OTHER REPORTABLE STDS

If you want to report a case of **chancroid**, please call 609-826-4869 to discuss further.

REPORTING CLINIC INFORMATION

PERSON COMPLETING FORM (first) (last)	EXAMINING PROVIDER (first) (last)	DATE

FACILITY NAME	TELEPHONE *(direct line)*

ADDRESS (street) (city) (state)	ZIP CODE

Thank you for reporting a STD. All information will be managed with the strictest confidentiality.