

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)

Race: (mark all that apply)

American Indian/Alaska Native

Asian/Asian American

Black/African American

Native Hawaiian/
Other Pacific Islander

White

Other: _____

Unknown

Country of birth:

United States

Other: _____

Unknown

Patient informed of syphilis results:

Yes

No

Unknown

Gender: (mark one only)

Male

Female

Transgender (M to F)

Transgender (F to M)

Pregnant:

No

Unknown

Yes

weeks:

Due date: (MM-DD-YY)

HIV tested at this visit:

Yes

Result:

Positive Negative

No

Previous positive

Patient previously tested for syphilis:

Yes

Latest date: (MM-DD-YY)

Result: _____

Patient on PrEP?

Yes

No

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.

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Patient last name:

Medical record number:

SPECIMEN COLLECTION

Specimen collection: (MM-DD-YY)

Reason for test: (mark all that apply)

- Signs/symptoms Pregnant Other:
 Screening Exposure

Non-Treponemal

- USR or } Reactive: Yes No
 RPR or } Titer: _____
 VDRL } 1: _____

Treponemal

- TP-PA or } Reactive: Yes No
 FTA-ABS or } Titer: _____
 Trep EIA } 1: _____

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:** Not Treated for Syphilis **Treatment date:** (MM-DD-YY)
 Benzathine penicillin G: 2.4 million units IM in a single dose Other:
 Doxycycline: 100 mg po BID x 14 days

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:** Not Treated for Syphilis **Treatment dates:** (MM-DD-YY)
 Benzathine penicillin G: 7.2 million units total, administered as 3 doses of 2.4 million units IM each at 1-week intervals Other:
 Doxycycline: 100 mg po BID x 28 days

OTHER

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

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