

RAPID SYPHILIS HEALTH CHECK CASE REPORT FORM

Form Instructions

- Health care providers should use this form to report reactive rapid syphilis tests.
- All case reports are classified as private under the Minnesota Government Data Practices Act (Minnesota Statutes, section 13.3805).
- **Return completed form by confidential fax: 1-800-298-3775, by phone to Cindy Lind Livingston: 651-201-4024, or by mail: Minnesota Department of Health STD/HIV/TB Section, Attn. Cindy Lind Livingston, PO Box 64975, St Paul, MN, 55164-0975.**
- **Do NOT email the completed form.**
- TYPE or PRINT clearly in CAPITAL LETTERS using black ink.

Specimen Collection

Specimen collection: (MM-DD-YY)

___/___/___

Patient had a reactive syphilis screening?

Yes No Unknown

Patient informed of result?

Yes No Unknown

Patient Information

Patient last name:

Patient phone:

Patient first name:

M.I.:

Patient street address:

Apt/unit #:

City/town:

State:

Zip:

Homeless

Address unknown

Date of birth: (MM-DD-YYYY)

___/___/___

Gender: (mark one only)

- Male
 Female
 Transgender (M to F)
 Transgender (F to M)

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

Provider Information

Screening facility/clinic name:

Screening facility phone:

Confirmatory testing facility where patient was referred:

Confirmatory testing facility street address:

Confirmatory facility phone:

City:

State:

Zip:

For questions on reporting rapid tests, please contact Karmen Dippmann, Syphilis Prevention Coordinator, by phone at 651-503-2708, or email at karmen.dippmann@state.mn.us.



Minnesota Department of Health, STD/HIV/TB Section
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