



Phone: 1 (888) 374-8824 Confidential fax: (801) 538-9923 Email: reporting@utah.gov

Syphilis confidential case report form

Instructions

Complete all sections of this form utilizing available data and fax or email* the completed form to Utah public health. As syphilis is a reportable disease, client consent to release this information to Utah public health is **not required** and disease reporting is mandatory per Utah State Health Code 26B.

*case reports submitted via email need to be sent securely via an encryption service such as Virtru.

Demographic information

Last name:	First name:	MI:	
Address:	City:	State:	ZIP:
Phone #1:	Phone #2:	Phone #3:	
Date of birth: ____/____/____	Age:	Birth sex: (check one) ☐ M ☐ F	
Current gender: (check one) ☐ M ☐ F ☐ FTM ☐ MTF ☐ Non-binary ☐ Other, specify: _____			
Race: (Check all that apply) ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Unknown ☐ Other, specify: _____			
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown			
Primary language: ☐ English ☐ Spanish ☐ Other, specify: _____			

Laboratory information

Attach a copy of the lab results

Rapid test information (if applicable)

Date of positive test result: _____ Test lot number: _____
Test expiration date: ____/____/____

Treatment information

For early syphilis (primary, secondary, and early non-primary non-secondary), treat with 1 dose of Benzathine penicillin OR a 14-day regimen of doxycycline. For late/unknown duration syphilis, treat with 3 weekly doses of Benzathine penicillin OR a 28-day regimen of doxycycline. Pregnant women can only be treated with penicillin. See [CDC STD Treatment Guidelines](#) for complete treatment guidelines including alternate treatment regimens.

Syphilis

Patient name: _____

Treatment:

Treatment date: ____/____/____

☐ Benzathine penicillin G 2.4 MU IM

Dates of additional doses of penicillin ____/____/____, ____/____/____

☐ Doxycycline 100 mg orally BID x 14 days☐ Doxycycline 100 mg orally BID x 28 days☐ Other, specify: _____**Reporting**

Reporter's name: _____

Phone number: _____

Reporter's agency: _____

Date reported to public health: ____/____/____

Clinical information

Clinician name: _____ Clinician phone #: () ____ - ____

Pregnant: ☐ Yes ☐ No ☐ Unknown ☐ N/A

If yes, estimated due date: ____/____/____

Date of last HIV test: ____/____/____ Test result: ☐ Pos. ☐ Neg. ☐ Equivocal ☐ UnknownIs the patient MSM (a man who has sex with men): ☐ Yes ☐ No ☐ Unknown ☐ N/ASyphilis stage: ☐ Primary ☐ Secondary ☐ Early non-primary non-secondary ☐ Unknown or late

Date of last negative syphilis test: ____/____/____

Syphilis related adverse outcomes: ☐ Ocular manifestations ☐ Otic manifestations
☐ Neurologic manifestations ☐ Late clinical manifestations

Please note: _____

Syphilis related symptoms:☐ Abdominal pain☐ Condyloma lata☐ Painful sex☐ Alopecia (hair loss)☐ Discharge or MPC☐ Pharyngitis (sore throat)☐ Balanitis☐ Dysuria☐ Proctitis☐ Bleeding☐ Ectopy☐ Rash☐ Cervical friability☐ Epididymitis☐ Swelling/inflammation☐ Cervical motion tenderness☐ Lymphadenopathy☐ Chancres/lesions/sores/ulcers☐ Mucous patch

Syphilis

Patient name: _____

☐ Other:

Sexual contact management

If known, complete the following information for all partners the patient has had sexual contact within the time periods listed below based on their stage of syphilis.

Primary: 3 months prior to symptom onset

Secondary: 6 months prior to symptom onset

Early non-primary non-secondary: 1 year prior to diagnosis

Late/unknown duration: 1 year prior to diagnosis plus long-term partners

Name: _____ Sex: ☐ M ☐ F DOB / age: _____

Address: _____ Phone: () _____ - _____

Other contact info: _____

Preventative treatment given (if applicable): _____ Date: ____/____/____

Name: _____ Sex: ☐ M ☐ F DOB / age: _____

Address: _____ Phone: () _____ - _____

Other contact info: _____

Preventative treatment given (if applicable): _____ Date: ____/____/____

Name: _____ Sex: ☐ M ☐ F DOB / age: _____

Address: _____ Phone: () _____ - _____

Other contact info: _____

Preventative treatment given (if applicable): _____ Date: ____/____/____