

# SURVEILLANCE MORBIDITY REPORT (Instructions)

## HEALTH PROVIDER INFORMATION

**Report Date:** enter date submitting report to STD Program.  
**Reporting Facility:** enter name of your facility or organization.  
**Laboratory used:** enter name of laboratory performing tests.  
**Requesting Physician:** enter requesting physician's name.  
**Telephone:** enter requesting physician's telephone.  
**Fax:** enter requesting physician's facsimile number.  
**Reporting Official:** enter name of person responsible for submitting infectious disease reports for your facility.  
**Location of Health Facility:** enter reporting facility's address.

## PATIENT DEMOGRAPHIC INFORMATION

**Last Name, First name:** enter patient's last and first names in designated areas.  
**Medical record Num:** enter patient's medical record number or identifier.  
**Date of Birth:** enter patient's date of birth using numerical digits (example 02/03/82).  
**Number and Street Address:** enter patient's house or building number and street name.  
**Apt. Num:** enter number or alphabet to denote apartment identifier.  
**City, State:** enter patient's city of residence and state.  
**Zip Code:** enter zip code number.  
**Telephone:** enter patient's home telephone number.  
**Work/Cell:** enter patient's cell telephone number.  
**Emergency Contact:** enter name of an emergency contact person for the patient.  
**Telephone:** enter emergency contact's telephone number.  
**Gender:** enter patient's gender at birth.  
**Race:** enter patient's race.  
**Marital Status:** enter patient's marital status.  
**Ethnicity:** enter patient's ethnicity status Hispanic or Latino, Not Hispanic or Latino, or Unknown.  
**Is Patient Pregnant?** enter yes, or no.

## PATIENT MEDICAL HISTORY

**Reason for Exam:** enter patient's chief complaint for seeking health care.  
**Diagnosis:** enter physician's diagnosis by checking box to left of infection. If syphilis is checked, please specify syphilis stage by checking box to left of appropriate syphilis stage box.  
**Symptoms:** enter description of symptoms such as location and type of chancre, rash, discharge, or other symptoms, and date of symptom onset, then enter symptom duration, and check box about whether the patient was counseled about partner notification. (Partner Notification – health provider or the patient informs sexually exposed candidates to promptly seek health care).  
**Laboratory Test:** enter test type (such as smear, culture, urine, DNA Probe, darkfield, RPR, VDRL, MHA-TP, FTA-ABS, FTA-IgM).  
**Date of Test:** enter date specimen collected.      **Type of Test:** enter test type.  
**Result:** enter test result.      **Treatment:** enter current infection information.  
**Date of Treatment:** enter treatment date.      **Medication/drug:** enter medication name.  
**Dosage:** enter medication/drug amount.      **Comments:** enter other comments or historical STD episodes.

**Is this a non-compliant patient?** Enter yes or no. If yes, complete emergency contact information above.

A non-compliant patient is a person deemed in need of STD treatment; however after several provider communications, the patient fails to return to the provider's office to comply with or fulfill the provider's treatment plan. With the home address, telephone, and emergency contact (next of kin) information, the STD Program will follow-up with non-compliant patients.

Additional surveillance morbidity report forms are available at our website:  
[http://dchealth.dc.gov/services/special\\_programs/std/reports2001.shtm](http://dchealth.dc.gov/services/special_programs/std/reports2001.shtm).