



Draft

# ILLINOIS DEPARTMENT OF PUBLIC HEALTH ILLINOIS CONFIDENTIAL MORBIDITY REPORT OF SEXUALLY TRANSMITTED INFECTIONS

## PATIENT INFORMATION

FIRST NAME

M.I.

Expedited Partner Therapy (EPT) given to patient with CHLAMYDIA and/or GONORRHEA for partner(s).

☐ Yes ☐ No ☐ Unknown

If yes, for how many partners?

LAST NAME

IDOC #

STREET ADDRESS

APARTMENT NUMBER

CITY

STATE

ZIP CODE

COUNTY OF RESIDENCE

PHONE NUMBER

DATE OF BIRTH

RACE (Select All That Apply)

ETHNICITY

☐ White☐ American Indian or Alaskan Native☐ Other☐ Black or African American☐ Native Hawaiian or Other Pacific Islander☐ Unknown☐ Asian☐ Hispanic or Latinx☐ Not Hispanic or not Latinx☐ Unknown

SEX AT BIRTH

CURRENT GENDER

SEX OF SEX PARTNER(S) (Select All that Apply)

PREGNANT ☐ Yes ☐ No

EST. DUE DATE

☐ Male☐ Female☐ Unknown☐ Male☐ Female☐ Something Else☐ Transgender Male (FTM)\*☐ Transgender Female (MTF)\*☐ Transgender Unknown☐ Unknown☐ Male☐ Female☐ Something Else☐ Transgender Male (FTM)\*☐ Transgender Female (MTF)\*☐ Transgender Unknown☐ Unknown

## DIAGNOSIS

Chlamydia

Gonorrhea

Other STIs

Syphilis Stage

Syphilis Symptoms

☐ Genito-urinary ☐ Rectal☐ Ophthalmia ☐ PID\*☐ Pneumonia ☐ LGV\*☐ Other:☐ Genito-urinary ☐ Rectal☐ Ophthalmia ☐ DGI\*☐ Pharyngeal ☐ PID\*☐ Other:☐ Chancroid

DATE OF TEST/EXAM

/ /

☐ Primary☐ Secondary☐ Early, NPNS\*☐ Late or Unknown☐ Congenital☐ Lesion/Chancere ☐ None☐ Rash (P/P\* or GBR\*)☐ Neurologic:☐ Ocular:☐ Otic:☐ Other:

## LABORATORY TEST(S) RELATED TO DIAGNOSIS

Chlamydia Test

Gonorrhea Test

Syphilis Tests

DATE POSITIVE TEST COLLECTED

DATE POSITIVE TEST COLLECTED

Serologic Screening Test: RPR, VDRL

DATE OF TEST / /

RESULT

☐ Pos☐ Neg

Titer 1: / /

Serologic Confirmatory Test: FTA-ABS, TP-PA, EIA

DATE OF TEST / /

RESULT

☐ Pos☐ Neg

Darkfield / DFA-TP or PCR (from lesion)

DATE OF TEST / /

RESULT

☐ Pos☐ Neg

CSF-VDRL

DATE OF TEST / /

RESULT

☐ Pos☐ NegSyphilis Neurologic Involvement ☐ Verified (Positive CSF-VDRL) ☐ Possible

## FACILITY WHERE SPECIMEN WAS COLLECTED

## FACILITY WHERE PATIENT WAS TREATED

Name

Name

Address

Address

City

Phone

City

Phone

Name of Person Completing Form

If you need assistance in sex partner referral, need additional forms, etc., call your local health department STI program.

 Submit this report  
to your local health  
department:

 If NO local  
health  
department,  
contact:

 Illinois Department of Public Health  
ATTN: STI Section  
525 W. Jefferson St., Ground Floor  
Springfield, IL 62761  
Phone: 217-782-2747

Updated 2022

Reported by: