



STD Surveillance
Orange, Osceola, Brevard,
Seminole Counties

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**FLORIDA CONFIDENTIAL REPORT OF
SEXUALLY TRANSMITTED DISEASES**

"Protecting Your Health...It's what we do"

Sex assigned at birth: FEMALE / MALE
Pregnant? YES / NO
Pregnancy EDD _____

Patient Name: _____
DOB: _____ **SSN:** _____
Address: _____
Phone: _____
Email: _____

Please print legibly OR use a label.

RACE: WHITE BLACK OTHER AM INDIAN/ALASKAN ASIAN/PAC ISLANDER
ETHNICITY: Hispanic / Non-Hispanic

Provider Name: _____ **Provider Phone:** _____

Provider Address: _____

CASES OF SYPHILIS MUST BE REPORTED TO DOH STD WITH TREATMENT BY THE NEXT BUSINESS DAY

SYPHILIS

Reason for visit:	Symptoms:	Previous history of syphilis infection? YES / NO Previous titer (if known): _____ Date of last negative RPR: _____
Collection date	Symptom onset date	# of sexual partners (within past year):
Reporting laboratory	Sexual orientation	
<u>Confirmatory tests</u> ___ TP-PA positive ___ FTA-ABS positive ___ IgG-EIA positive ___ MHA-TP ___ TP-AB positive <u>Diagnosis</u> ___ Primary ___ Secondary ___ Early Latent (< 1 yr) ___ Late Latent ___ Tertiary ___ Congenital	<u>Treatment dates:</u> 2.4 BIC #1 _____ 2.4 BIC #2 _____ 2.4 BIC #3 _____ ___ Doxycycline 100 BID x 14d Date _____ ___ Doxycycline 100 BID x 28d Date _____ <u>IF PREGNANT</u> Was sex partner(s) treated? YES / NO If NO, was sex partner(s) referred to the Health Department? YES / NO	<u>Sexual Partner(s) information (if known/given):</u>