NYC Health

New York City Department of Health and Mental Hygiene
Universal Reporting Form

To report an **immediately notifiable** disease or condition, an outbreak among three or more persons or an unusual manifestation of any disease or condition, or any newly apparent or emerging disease or syndrome, call the Provider Access Line at **866-692-3641**.

Diseases and conditions in green and marked with * are **immediately notifable**; those marked with † are immediately notifiable if case meets the risk group criteria on page 2. Report by calling **866-692-3641**.

For all other diseases and conditions, report using Reporting Central online via NYCMED at **www.nyc.gov/health/nycmed**, mail this form to the NYC Department of Health and Mental Hygiene, 42-09 28th Street, CN-22, Long Island City, NY 11101, or call **866-692-3641** for the appropriate fax number.

Go to **www.nyc.gov/health/diseasereporting** for more information.

Patient Information

Patient Last Name	First Name	Middle Name	**DATE OF REPORT**
Patient AKA: Last Name	AKA: First Name	AKA: Middle Name	_____ /_____ /_____

Age	Date of Birth	Country of Birth	Social Security Number	**DATE OF DIAGNOSIS**
	_____ /_____ /_____			_____ /_____ /_____
If patient is a child, Guardian Last Name		Guardian First Name	Guardian Middle Name	

Medical Record Number	Medicaid Number	**DATE OF ILLNESS ONSET**
Patient Home Address	City / State / Zip Code	_____ /_____ /_____

Country

Borough: ☐ Manhattan ☐ Bronx ☐ Brooklyn ☐ Queens ☐ Staten Island ☐ Unknown ☐ Not NYC

Email Address	Mobile Phone	Home Phone	☐ Homeless

Sex: ☐ Male ☐ Female ☐ Transgender MTF ☐ Transgender FTM ☐ Unknown

Race: ☐ Black ☐ White ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Other: _____ ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Is patient alive? ☐ Yes ☐ No ☐ Unknown
If no, date of death: _____ /_____ /_____

Is patient pregnant? ☐ Yes ☐ No ☐ Unknown
If yes, due date: _____ /_____ /_____

Is case suspected to be due to healthcare associated transmission? ☐ Yes ☐ No ☐ Unknown

Was patient admitted to hospital? ☐ Yes ☐ No ☐ Unknown
Admission date: _____ /_____ /_____
Discharge date: _____ /_____ /_____

Is patient a newborn infant? ☐ Yes ☐ No ☐ Unknown
If yes, name of hospital where infant was born _____
Name of facility where infant's mother obtained prenatal care _____

Foreign travel

Countries _____ **Date returned to U.S.** _____ /_____ /_____

Other Information

REPORTER

Name of Person Reporting Disease	Email address	Phone
Name of Facility of Person Reporting Disease	National Provider Identifier (NPI) Code	Permanent Facility Identifier (PFI) Code
Facility Street Address	City / State / Zip Code	

FACILITY

Name of Hospital/Healthcare Facility Providing Care for Patient	Facility National Provider Identifier (NPI) Code	Permanent Facility Identifier (PFI) Code
Facility Street Address	City / State / Zip Code	

LAB

Name of Testing Laboratory	Phone	CLIA Number
Laboratory Street Address	City / State / Zip Code	

PROVIDER

Name of Provider Caring for Patient	National Provider Identifier (NPI) Code	Fax
Email address	Phone	Mobile
Provider Street Address	City / State / Zip Code	

Patient Last Name	First Name	Medical Record Number

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☐ **Amebiasis†**

☐ **Anaplasmosis** (Human granulocytic anaplasmosis)

Animal bite – see Environmental Conditions section on page 3. See rabies if potential for exposure.

☐ **Anthrax***

☐ **Arboviral infections,** acute*

Specify which virus: _____
If Chikungunya, Dengue, West Nile, Yellow Fever or Zika report as such.
Attach copies of diagnostic laboratory results if available.

☐ **Babesiosis**

☐ **Botulism***
◯ Foodborne ◯ Infant ◯ Wound

☐ **Brucellosis***

☐ **Campylobacteriosis†**

Carbon Monoxide poisoning* – see Poisonings section on page 3

Chancroid – see STD section on page 4

☐ **Chikungunya**

Chlamydia – see STD section on page 4

☐ **Cholera***

Creutzfeldt-Jakob disease – see Transmissable spongiform encephalopathy

☐ **Cryptosporidiosis†**

☐ **Cyclosporiasis†**

☐ **Dengue**
Attach copies of dengue diagnostic laboratory results if available.

☐ **Diphtheria***

Drownings – see Environmental Conditions section on page 3

☐ **Ehrlichiosis** (Human monocytic ehrlichiosis)
If human granulocytic anaplasmosis report as anaplasmosis.

☐ **Encephalitis**
If Jul.1–Oct. 31 consider and test for West Nile virus. If due to another reportable disease (e.g. Lyme, West Nile, arbovirus), report under the other disease.

☐ ***Escherichia coli*** O157:H7 infection†

Falls from windows – see Environmental Conditions section on page 3

☐ **Food poisoning** in a group of 2 or more individuals*

☐ **Giardiasis†**

☐ **Glanders***

Gonorrhea – see STD section on page 4

Granuloma inguinale – see STD section on page 4

☐ ***Haemophilus influenzae*** (invasive disease)†

Test type:
◯ Culture ◯ Antigen
◯ PCR ◯ Gram stain
◯ Other _____

Specimen Source:
◯ Blood ◯ CSF ◯ Unknown
◯ Other _____

Specify Serotype:
◯ Type B ◯ Not typeable
◯ Not tested ◯ Unknown
◯ Other _____

☐ **Hantavirus disease***

☐ **Hemolytic uremic syndrome**

FOR ALL HEPATITIS REPORTS

Jaundice ◯ Yes ◯ No ◯ Unknown

ALT (SGPT) value:_____ ◯ Unknown

Lab reference range:_____ ◯ Unknown

☐ **Hepatitis A†**
Total Ab to Hepatitis A is NOT reportable.
IgM anti-HAV: ◯ Pos ◯ Neg ◯ Unknown

☐ **Hepatitis B†**
Report at least one positive hepatitis B test result. Total Ab to Hepatitis B is not reportable.
IgM anti-HBc: ◯ Pos ◯ Neg ◯ Unknown
HBsAg: ◯ Pos ◯ Neg ◯ Unknown
HBeAg: ◯ Pos ◯ Neg ◯ Unknown
HBV Nucleic Acid: ◯ Pos ◯ Neg ◯ Unknown

If IgM is positive, describe symptoms and risk in comments box on last page.

Hepatitis B in pregnancy
Report cases in Reporting Central or fax IMM-5 form to 347-396-2558. For more information, call 347-396-2403.

☐ **Hepatitis C†**
Check all that apply:
◯ EIA pos
◯ HCV Nucleic Acid (e.g.PCR) pos

Is this an acute infection?
◯ Yes
◯ No
◯ Unknown

Herpes, neonatal – see STD section on page 4

HIV/AIDS
Report using the New York State Provider Report Form (PRF). Call 518-474-4284 for forms or 212-442-3388 for more information.

Influenza

☐ Suspected novel viral strain with pandemic potential (e.g., avian H5N1 or H7N9)*

☐ Death in a child aged 18 or younger

Lead poisoning – see Poisonings section on page 3

☐ **Legionellosis†**
Specify positive test:
◯ Culture ◯ Urine antigen
◯ DFA ◯ Serology
◯ NAAT or PCR

☐ **Leprosy** (Hansen's disease)

☐ **Leptospirosis**

☐ **Listeriosis†**

☐ **Lyme disease**
Erythema migrans present?
◯ Yes ◯ No ◯ Unknown

☐ **Lymphocytic choriomeningitis virus**

Lymphogranuloma venereum – see STD section on page 4

☐ **Malaria†**
Select at least one of the following:
◯ falciparum ◯ vivax ◯ malariae
◯ ovale ◯ undetermined
Complete Foreign Travel section on page 1.

☐ **Measles** (rubeola)*

☐ **Melioidosis***

☐ **Meningitis,** bacterial
Specify bacteria identified _____

☐ **Meningococcal disease,** invasive (including meningitis) *
Test type/Specimen source:
◯ Blood culture ◯ CSF culture
◯ Antigen test from CSF ◯ Gram stain
◯ PCR ◯ Other _____

☐ **Monkeypox***

☐ **Mumps†**

☐ **Paratyphoid fever†**

☐ **Pertussis** (whooping cough)†

☐ **Pesticide poisoning -** see Poisonings section on page 3

☐ **Plague***

Poisoning – see Poisonings section on page 3

☐ **Poliomyelitis***

☐ **Psittacosis**

☐ **Q Fever***

☐ **Rabies and exposure to rabies*** – see animal bites in Environmental Conditions section on page 3

☐ **Ricin poisoning***

☐ **Rickettsialpox**

☐ **Rocky Mountain spotted fever**

☐ **Rubella** (German measles)*

☐ **Rubella syndrome,** congenital

☐ **Salmonellosis†**
Serogroup: _____
If due to Salmonella typhi or paratyphi, select Typhoid or Paratyphoid Fever.

☐ **Severe or novel coronavirus** (e.g., SARS or MERS-CoV)*

☐ **Shiga-toxin** producing *Escherichia coli* (STEC) infection†

☐ **Shigellosis†**

☐ **Smallpox** (variola)*

☐ **Staphylococcal enterotoxin B poisoning***

☐ ***Staphylococcus aureus,*** vancomycin intermediate (VISA) and resistant (VRSA)*
Source: _____
MIC (µg/ml): _____

☐ ***Streptococcus*** (Group A and B) invasive†
Specify Source: ◯ Blood ◯ CSF ◯ Unknown
◯ Other, Specify:_____

Syphilis, including congenital – see STD section on page 4

☐ **Tetanus**

☐ **Toxic shock syndrome**

☐ **Trachoma**

☐ **Transmissible spongiform encephalopathy**
(Creutzfeldt-Jakob disease and variants)
Testing done: _____
(e.g. 14-3-3 on CSF, brain biopsy, autopsy, EEG/MRI)

☐ **Trichinosis**

Tuberculosis – see Tuberculosis section on page 3

☐ **Tularemia***

☐ **Typhoid fever†**

☐ **Vaccinia disease** (adverse events associated with smallpox vaccination)*

☐ ***Vibrio* species,** non-cholera
Specify species:_____

☐ **Viral hemorrhagic fever***

☐ **West Nile** fever and viral neuroinvasive disease (e.g., meningitis and encephalitis)
Attach copies of diagnostic laboratory results if available.

☐ **Yellow fever***
Attach copies of diagnostic laboratory results if available.

☐ **Yersiniosis,** non-plague†

☐ **Zika**

***Report suspected and confirmed cases immediately to 1-866-692-3641** **†If case meets any of the risk group criteria below, report immediately to 1-866-692-3641**

Risk Groups for Disease Exposure/Transmission

Complete this section for diseases marked with † and if case meets any criteria, report it immediately to 1-866-692-3641.

Patient works in:
☐ Childcare ☐ Health care facility ☐ Long-term care facility/Nursing home ☐ Clinical/Research laboratory
☐ Unknown ☐ Food service ☐ Correctional facility ☐ Position with routine animal contact ☐ Other _____

Patient attends/resides in:
☐ Assisted living facility ☐ School ☐ Dormitory ☐ Long-term care facility/nursing home
☐ Unknown ☐ Correctional facility ☐ Shelter ☐ Day care/group baby-sit ☐ Other congregate living facility (specify: _____)

Patient Last Name	First Name	Medical Record Number

Environmental Conditions

☐ **Animal bites**

☐ **Exposure to rabies***

Including a bite or other exposure to any animal confirmed to have rabies, or from any rabies vector species (raccoon, bat, skunk, fox or coyote), or any mammal exhibiting signs suggestive of rabies.

Animal Species: _____

Breed: _____ Color(s): _____

◯ Owned ◯ Stray ◯ Unknown

Owner's Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Date of Bite: ____/____/____ Area of body bitten:

Activity at time of bite: _____

Place of occurrence: _____

Treatment given: _____

Rabies prophylaxis ◯ Yes ◯ No

HRIG ◯ Yes ◯ No

Rabies Vaccine ◯ Yes ◯ No

☐ **Drownings**

Respiratory impairment from submersion/immersion in liquid.

Drowning Location: _____

Outcome: ◯ Death ◯ Morbidity ◯ No Morbidity

☐ **Window Falls**

Falls from windows of buildings with 3 or more dwellings, by children aged 16 years and younger, report by calling 646-632-6204 or on Child Window Fall Notification Report paper form.

Poisonings

ROUTE OF EXPOSURE

◯ Ingestion
◯ Ocular
◯ Dermal
◯ Inhalation
◯ Aural
◯ Bite
◯ Sting
◯ IV

CHEMICAL

☐ **Lead**

For persons aged 16 and older indicate:

Employer _____

Employer phone _____

☐ **Carbon Monoxide***

Source: ◯ Furnace/Boiler ◯ Generator ◯ Vehicle ◯ Other _____

☐ **Arsenic** ☐ **Cadmium**
☐ **Mercury** ☐ **Pesticide**
☐ **Other** _____

QUANTITY

◯ Milliliter (mL) _____
◯ Mouthful _____
◯ Sip _____
◯ Tablespoon _____
◯ Tab/pill/cap _____
◯ Taste/lick/drop _____
◯ Teaspoon _____
◯ Unknown

DATE AND TIME OF EXPOSURE

____/____/____
____ ____ : ____ ____
◯ AM ◯ PM

REASON AND SETTING

Unintentional:
◯ General
◯ Environmental
◯ Indoor ◯ Outdoor
◯ Misuse
◯ Bite/sting
◯ Food poisoning
◯ Occupational
◯ Dietary
◯ Consumer product
◯ Pesticide
◯ Medication (accidental ingestion)
◯ Unknown

Intentional:
◯ Suspected suicide
◯ Misuse
◯ Abuse
◯ Unknown

Other:
◯ Contamination/ tampering
◯ Malicious
◯ Withdrawal

Adverse reaction:
◯ Drug
◯ Food
◯ Other
◯ Unknown

SYMPTOM ASSESSMENT (Check all that apply)

◯ None
◯ Nausea/vomiting/diarrhea
◯ Lethargic/stupor/coma
◯ Agitated
◯ Hypertensive
◯ Hypotensive
◯ Tachycardia
◯ Brachycardia
◯ Seizure
◯ Electrolyte abnormalities
◯ Cough/shortness of breath
◯ Ocular irritation
◯ Skin irritation
◯ Unknown
◯ Other _____

PROVIDER TREATMENT

◯ No therapy required
◯ Oral fluids
◯ Emesis
◯ Lavage
◯ Activated charcoal
◯ Cathartic
◯ Chelation
◯ Insect sting mgmt.
◯ Irrigated eye
◯ Oxygen
◯ Naxolone
◯ 50% Dextrose/Thiamine
◯ Alkalinize urine
◯ N-acetylcysteine (Mucromyst)
◯ Other _____

SPECIMEN SOURCE

◯ Capillary ◯ Venous ◯ Urine
◯ Other _____

Date Collected
____/____/____

Date Analyzed
____/____/____

Laboratory Accession Number
_____

Results (units) _____

Purpose of test:
◯ Initial ◯ Repeat
◯ Follow-up

VITAL SIGNS

Body Weight _____
◯ Pounds ◯ Kilograms

BP: __ __ __/ __ __ __

Resp: _____

Temp: _____ ◯ F ◯ C

Pulse: _____

Pupils:
◯ Dilated
◯ Constricted

Tuberculosis

Patient status at time of reporting:
◯ < 5 years old with LTBI
◯ TB suspect or case

Indicate all sites of disease for TB suspect or case:
◯ Pulmonary
◯ Lymphatic
◯ Bone/Joint
◯ Soft tissue/Muscles
◯ Peritoneal
◯ Meningeal
◯ Genitourinary
◯ Gastrointestinal
◯ Other: _____

Collection date: ___/___/___ ◯ Unknown

Laboratory Results:
Specimen Number: _____
◯ Unknown

Specimen Source:
◯ Sputum
◯ Tracheal aspirate
◯ Bronchial fluid/Broncho-alveolar lavage
◯ Lymph node
◯ Lung tissue
◯ Pleural fluid
◯ Pleura
◯ Blood
◯ Urine
◯ Other: _____

AFB Smear:
◯ Positive
Smear Grade: ◯ suspicious ◯ 1+ rare ◯ 2+ few ◯ 3+ moderate ◯ 4+ numerous
◯ Negative ◯ Pending
◯ Not Done ◯ Unknown

Nucleic Acid Amplification (NAA):
Test type: _____
◯ Positive ◯ Negative
◯ Pending ◯ Not Done
◯ Unknown

Mutation analysis test type: _____
Mutation detected?
◯ Yes ◯ No ◯ Unknown
If yes, list the genes with mutations: _____

M. tb Complex Culture:
◯ Positive ◯ Negative
◯ Pending ◯ Contaminated
◯ Not Done ◯ Unknown

Pathology consistent with TB:
◯ Yes ◯ No ◯ Not Done ◯ Unknown
Date: ____/____/____
Pathology Specimen Number: _____
Pathology Specimen Source _____
Pathology Findings: _____

Chest X-Ray: ____/____/____
◯ Normal
◯ Abnormal
◯ Consistent with TB
◯ Evidence of Cavity
◯ Evidence of Miliary TB
◯ Not consistent with TB

CT Scan ◯ / MRI ◯ ___/___/___

Body Site:
◯ Chest ◯ Neck
◯ Abdomen ◯ Pelvis
◯ Head ◯ Spine
◯ Unknown ◯ Other: _____

◯ Normal
◯ Abnormal
◯ Consistent with TB
◯ Evidence of Cavity
◯ Evidence of Miliary TB
◯ Not consistent with TB

Test for TB Infection:
◯ History of positive test result
Year (yyyy): _____

Date of most recent test: ___/___/___

Type of Test:
◯ Tuberculin Skin Test (TST/PPD)
◯ QuantiFERON® TB-Gold in tube (QFT-GIT)
◯ T-Spot.TB
◯ Other: _____

Result:
◯ Positive ◯ Negative ◯ Unknown
◯ Indeterminate ◯ Borderline
Induration _____ mm

Treatment: On Anti-TB Medications ◯ Yes ◯ No ◯ Unknown

Please complete for each medication: Dose (mg) Frequency/day Start Date

Medication	Dose (mg)	Frequency/day	Start Date
Isoniazid (INH)			/ /
Rifampin (RIF)			/ /
Pyrazinamide (PZA)			/ /
Ethambutol (EMB)			/ /
Other 1 _____			/ /
Other 2 _____			/ /
Other 3 _____			/ /

Airborne Isolation: ◯ Yes ◯ No ◯ Unknown

If yes, date initiated: ___/___/___ Date discontinued: ___/___/___

Describe other medical problems or other pertinent information in the comments box on the last page.

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Patient Last Name	First Name	Medical Record Number

Sexually Transmitted Diseases

For All STD Reports

As of the date of this report,

Were any of this patient's sex partners notified of possible exposure to an STD?
(Check all that apply)

- ◯ Yes, our office notified the partner(s)
- ◯ Yes, the patient was asked to notify partner(s)
- ◯ No
- ◯ Unknown

Did you provide treatment for any of this patient's partners? (Check all that apply)

- ◯ Yes, I saw the sex partner(s) in my office
- ◯ Yes, I gave extra medication for ___(#) partner(s)
- ◯ Yes, I wrote a prescription for ___(#) partner(s)
- ◯ Yes, some other way (specify):_____
- ◯ No
- ◯ Unknown

Is the patient on pre-exposure prophylaxis (PrEP) to prevent HIV infection?

- ◯ Yes, started PrEP at time of current STD diagnosis
- ◯ Yes, already on PrEP at time of current STD diagnosis
- ◯ No
- ◯ Unknown

Please indicate gender of sexual partners in the past year:
(Check all that apply)

- ◯ Males
- ◯ Females
- ◯ Transgender Male to Female
- ◯ Transgender Female to Male
- ◯ Unknown

☐ **Chancroid**

Specify type of specimen:

◯ Penile ◯ Vaginal ◯ Endocervical
◯ Anorectal ◯ Oropharyngeal
◯ Other: _____

Specimen collection date: ____ /____ /_____

Treatment: _____

Treatment date: ____/____ /____ ◯ Unknown

☐ **Chlamydia** (CT)

Specify type of specimen:

◯ Endocervical ◯ Urethral ◯ Anorectal
◯ Oropharyngeal ◯ Urine
◯ Other: _____

Specify test type:

◯ Culture ◯ Nucleic acid amplification
◯ Nucleic acid hybridization
◯ EIA ◯ DFA
◯ Other: _____

Specimen collection date: ____ /____ /_____

Treatment: _____

Treatment date:___ /____ /___ ◯ Unknown

☐ **Gonorrhea*** (GC)

Specify type of specimen:

◯ Endocervical ◯ Urethral ◯ Anorectal
◯ Oropharyngeal ◯ Urine
◯ Other: _____

Specify test type:

◯ Culture ◯ Nucleic acid amplification
◯ Nucleic acid hybridization
◯ Other: _____

Specimen collection date: ____ /____ /_____

Treatment 1*: _____mg/gram

Treatment 2*: _____mg/gram

Treatment date: ____ /____ /_____ ◯ Unknown

☐ **Granuloma inguinale**

Specify type of specimen:

◯ Penile ◯ Vaginal ◯ Endocervical
◯ Anorectal ◯ Oropharyngeal
◯ Other _____

Specimen collection date: _____ /____ /_____

Treatment: _____

Treatment date: ____ /____ /____ ◯ Unknown

☐ **Herpes, neonatal**

Herpes simplex virus infection in infants aged 60 days and younger.

◯ Clinical diagnosis
◯ Lab confirmed diagnosis
◯ Culture ◯ PCR
◯ Other _____

Herpes type: ◯ Type 1 ◯ Type 2 ◯ Not typed

Clinical Syndrome (Check all that apply)

◯ Skin, eye, mucous membrane infection
◯ CNS involvement
◯ Disseminated disease

Herpes lesions present?

◯ Yes, anatomic site_____
◯ No
◯ Unknown

Specimen collection date:____ /____ / ___

Treatment for infant:_____

Treatment date: ____ /____ /___ ◯ Unknown

Mother's Name: _____

Mother's DOB: ____ /____ /_____

Birth Hospital _____

Mother's Labor and Delivery Medical Record No:

_____

_____

☐ **Lymphogranuloma venereum**

Clinical Presentation (Check all that apply)

◯ Proctitis ◯ Lymphadenopathy
◯ Buboe ◯ Skin lesion
◯ Other: _____

Specimen collection date: ____ /____ /_____

Treatment: _____

Treatment date: ____ /____ /____ ◯ Unknown

☐ **Syphilis****

Stage:

◯ Congenital
◯ Primary, chancre present (Check all that apply)
◯ Penile ◯ Vaginal ◯ Endocervical
◯ Anorectal ◯ Oropharyngeal
◯ Other: _____

◯ Secondary (Check all that apply)
◯ Alopecia ◯ Condylomata
◯ Mucous patches ◯ Rash

◯ Early Latent
no symptoms, infection ≤ 1 year duration

◯ Late Latent
no symptoms, infection of > 1 year duration

◯ Tertiary, gumma or cardiovascular

Neurologic symptoms present?
◯ Yes ◯ No ◯ Unknown

Ocular symptoms present?
◯ Yes ◯ No ◯ Unknown

Otic symptoms present?
◯ Yes ◯ No ◯ Unknown

Treatment – list medication and dosage below:

_____

_____

_____

Treatment date:___ /____ /___ ◯ Unknown

Continue to next column

Syphilis Test Types: (Check all that apply)

1. Serologic tests for syphilis

A. Non-treponemal Test

◯ RPR ◯ Reactive ◯ Non-reactive

Titer _____

◯ VDRL ◯ Reactive ◯ Non-reactive

Titer _____

Specimen collection date: ____ /____ /_____

B. Treponemal Test

◯ TP-PA/MHA-TP ◯ Reactive ◯ Non-reactive
◯ FTA ◯ Reactive ◯ Non-reactive
◯ Treponemal IgG ◯ Reactive ◯ Non-reactive

Specimen collection date: ____ /____ /_____

2. Cerebrospinal fluid tests

◯ CSF VDRL ◯ Reactive ◯ Non-reactive
◯ CSF FTA ◯ Reactive ◯ Non-reactive
◯ Other Test: _____ Result _____

Specimen collection date: ____ /____ /_____

◯ Elevated CSF protein ◯ Yes ◯ No
◯ Elevated CSF leukocytes ◯ Yes ◯ No

Specimen collection date: ____ /____ /___

3. Organism visualization

◯ Darkfield ◯ Positive ◯ Negative

◯ Other Test: _____ Result _____

Specimen collection date: ____ /____ /_____

* For uncomplicated gonococcal infections of the cervix, urethra, anorectum or pharynx, CDC recommends dual therapy (irrespective of concurrent chlamydial infection) using BOTH Ceftriaxone 250mg IM AND Azithromycin 1g PO.

** Licensed health care providers can access current and historical syphilis test results and treatment information in the New York City Syphilis Registry to inform the diagnosis and management of syphilis in their patients. For more information, see the Syphilis Registry check at: http://www1.nyc.gov/assets/doh/downloads/pdf/std/hcp-syphilis-registry-check.pdf, or call 347-396-7201

Comments: