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 people 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 an asterisk (*) are immediately notifiable. Diseases and conditions marked with a dagger (†) are immediately notifiable if the case meets the risk group criteria on Page 2. Report by calling the Provider Access Line at 866-692-3641.

For all other diseases and conditions, report them by using the online Provider Reporting Interface and Secure Messenger (PRISM) via NYC.ID at **a816-health.nyc.gov/prism**; mailing this form to the NYC Department of Health and Mental Hygiene at 42-09 28th St., CN-22, Long Island City, NY 11101; or calling 866-692-3641 for the appropriate fax number. Visit **nyc.gov/health/diseasereporting** for more information.

Patient Information

Patient Last Name | Patient First Name | Patient Middle Name | **Date of Report** _____

Patient AKA: Last Name | Patient AKA: First Name | Patient AKA: Middle Name

Age | Date of Birth | Country of Birth | Social Security Number | **Date of Diagnosis** _____

Guardian Last Name (If Patient Is a Child) | 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 | ☐ Unhoused

Patient's sex assigned at birth:
☐ Male ☐ Female ☐ Unknown
☐ Sex assignment not listed here (specify): _____

Patient's ethnic or cultural groups (check all that apply):
☐ Black ☐ White ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Asian ☐ Arab
☐ Chinese ☐ Dominican ☐ Guyanese ☐ Haitian ☐ Indian ☐ Italian ☐ Jamaican ☐ Jewish ☐ Mexican
☐ Middle Eastern or North African ☐ Puerto Rican ☐ Russian ☐ Patient does not identify with any specific ethnic or cultural group
☐ Unknown ☐ Other (specify): _____

Does the patient identify as Hispanic or Latino?
☐ Yes, Hispanic or Latino
☐ No, not Hispanic or Latino
☐ Unknown

Patient's current gender identify (only if age 12 or older):
☐ Woman or girl ☐ Man or boy ☐ Unknown
☐ Transgender woman or transgender girl
☐ Transgender man or transgender boy
☐ Nonbinary or genderqueer person
☐ Gender identity not listed here (specify): _____

Patient's sexual orientation (only if age 12 or older):
☐ Gay or lesbian ☐ Straight or heterosexual ☐ Unknown
☐ Bisexual
☐ Queer
☐ Questioning or not sure
☐ Sexual orientation not listed here (specify): _____

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

Is the patient pregnant?
☐ Yes ☐ No ☐ Unknown
If yes, the patient's due date: _____

Is the case suspected to be due to health care-associated transmission?
☐ Yes ☐ No ☐ Unknown

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

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

Foreign Travel
Countries: _____ Date returned to the U.S.: _____

Other Information

Reporter

Name of Person Reporting Disease | Email Address | Phone | Fax

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 or Health Care Facility Providing Care for Patient | Facility National Provider Identifier (NPI) Code | Permanent Facility Identifier (PFI) Code

Facility Street Address | City | State | ZIP Code

Laboratory

Name of Testing Laboratory | Phone | Clinical Laboratory Improvement Amendment (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

Are you reporting as a civil surgeon? ☐ Yes ☐ No ☐ Unknown

Patient Last Name	First Name	Medical Record Number

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- ☐ **Amebiasis**†
- ☐ **Anaplasmosis** (human granulocytic anaplasmosis)
- ☐ **Animal bite** — see the Environmental Conditions section on Page 3. See **rabies** if potential for exposure.
- ☐ **Anthrax***
- ☐ **Arboviral infections, acute***
  - Specify 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 the Poisonings section on Page 3.
- ☐ **Chancroid** — see the STI section on Page 4.
- ☐ **Chikungunya***
- ☐ **Chlamydia** — see the STI section on Page 4.
- ☐ **Cholera***
- ☐ **Coronavirus, severe or novel** (e.g., SARS or MERS-CoV)*
- ☐ **COVID-19 (SARS-CoV-2)**
- ☐ **Creutzfeldt-Jakob disease*** — see **transmissible spongiform encephalopathy**.
- ☐ **Cronobacter** (in infants 12 months or younger)
- ☐ **Cryptosporidiosis**†
- ☐ **Cyclosporiasis**
- ☐ **Dengue**
  - Attach copies of dengue diagnostic laboratory results if available.
- ☐ **Diphtheria***
- ☐ **Drownings** — see the Environmental Conditions section on Page 3.
- ☐ **Ehrlichiosis** (human monocytic ehrlichiosis)
  - If human granulocytic anaplasmosis, report as anaplasmosis.
- ☐ **Encephalitis**
  - If July 1 through October 31, consider and test for West Nile virus. If due to another reportable disease (e.g., Lyme disease, West Nile, or arbovirus), report under that other disease.
- ☐ ***Escherichia coli* O157:H7 infection**†
- ☐ **Falls from windows** — see the Environmental Conditions section on Page 3.
- ☐ **Food poisoning in a group of two or more individuals***
- ☐ **Giardiasis**†
- ☐ **Glanders***
- ☐ **Gonorrhea** — see the STI section on Page 4.
- ☐ **Granuloma inguinale** — see the STI section on Page 4.
- ☐ ***Haemophilus influenzae* (invasive disease)***
  - Test type:
    ☐ Culture ☐ Antigen ☐ PCR
    ☐ Gram stain ☐ Other (specify): _____
  - Specimen source:
    ☐ Blood ☐ CSF ☐ Unknown
    ☐ Other (specify): _____
  - Specify serotype:
    ☐ Type B ☐ Not typeable
    ☐ Not tested ☐ Unknown
    ☐ Other (specify): _____
- ☐ **Hantavirus disease***
- ☐ **Hemolytic uremic syndrome**

Hepatitis Case Reporting

Acute Hepatitis — All Types (A, B, and C)

Jaundice: ☐ Yes ☐ No ☐ Unknown
ALT (SGPT) value: _____ ☐ Unknown
Total bilirubin value: _____ ☐ Unknown

- ☐ **Hepatitis A**†‡
  - Total Ab to hepatitis A is **not** reportable.
  - IgM anti-HAV: ☐ Positive ☐ Negative ☐ Unknown
- ☐ **Hepatitis B**†‡
  - Total anti-HBc is **not** reportable. Report positive results for all other hepatitis B tests. For acute hepatitis B (new infection), if no obvious risk factor for infection other than a medical procedure is identified, report immediately (or the next business day) to 866-692-3641:
  - IgM anti-HBc: ☐ Positive ☐ Negative ☐ Unknown
    HBsAg: ☐ Positive ☐ Negative ☐ Unknown
    HBeAg: ☐ Positive ☐ Negative ☐ Unknown
    HBV DNA (e.g., nucleic acid test or PCR): ☐ Positive ☐ Negative ☐ Unknown
  - If IgM anti-HBc is positive, describe symptoms, risk history, and risk factors in the comments box on Page 4.
  - Indicate sexual partners in the past year (check all that apply):
    ☐ Woman ☐ Man ☐ Unknown ☐ None
    ☐ Transgender woman ☐ Transgender man
- ☐ **Hepatitis B in pregnant or postpartum patients**‡
  - Maternal test results: HBsAg: ☐ Positive ☐ Negative
  - HBV DNA result: _____ IU/mL
  - Expected date of delivery: _____
  - Expected birth hospital: _____
  - Postpartum: Infant chart number: _____
  - Birth weight: _____ grams
  - Infant name (last name. first name. middle initial): _____, _____, ___
  - Infant birth date:
    Infant birth time: _____ ☐ a.m. ☐ p.m.
  - HBIG date:
    HBIG time: _____ ☐ a.m. ☐ p.m.
  - Hepatitis B vaccine (first dose) date: _____
  - Hepatitis B vaccine (first dose) time: _____ ☐ a.m. ☐ p.m.
  - Fax this form to 347-396-8846. For details, call 347-396-2403.
- ☐ **Hepatitis C**†‡
  - Report HCV antibody (EIA) and HCV RNA positive tests§ for acute cases:
    HCV antibody (EIA): ☐ Positive
    HCV RNA (e.g., nucleic acid test or PCR): ☐ Positive

‡ Describe symptoms, risk history, and risk factors in the comments box on Page 4.

§ Include laboratory-based or point-of-care test results. For more information on hepatitis reporting and care, visit **nyc.gov/site/doh/providers/health-topics/hepatitis.page**.

- ☐ **Herpes, neonatal** — see the STI section on Page 4.

HIV and AIDS

Acute HIV infection should be reported within 24 hours. HIV infection (not acute) and AIDS should be reported within seven days of diagnoses or receipt of laboratory results. Report using the New York State Provider Report Form (PRF). Call 518-474-4284 for forms or call 212-442-3388 for more information.

- ☐ **Influenza**
  - ☐ Suspected novel viral strain with pandemic potential (e.g., avian H5N1 or H7N9)*
  - ☐ Death in a child under 18 years of age
- ☐ **Lead poisoning** — see the 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**
- ☐ **Lymphocytic choriomeningitis virus or lymphogranuloma venereum** — see the STI section on Page 4.
- ☐ **Malaria**†
  - Select at least one of the following:
    ☐ Falciparum ☐ Vivax ☐ Malariae
    ☐ Ovale ☐ Undetermined
  - Complete the Foreign Travel section on Page 1.
- ☐ **Measles** (rubeola)*
- ☐ **Melioidosis***
- ☐ **Meningitis, bacterial**
  - Specify the bacteria identified: _____
- ☐ **Meningococcal disease, invasive** (including meningitis)*
  - Test type or specimen source:
    ☐ Blood culture ☐ CSF culture
    ☐ Antigen test from CSF ☐ Gram stain
    ☐ PCR ☐ Other (specify): _____
- ☐ **Mpox***
- ☐ **Mumps**†
- ☐ **Paratyphoid fever**†
- ☐ **Pertussis** (whooping cough)†
- ☐ **Pesticide poisoning** — see the Poisonings section on Page 3.
- ☐ **Plague***
- ☐ **Poisoning** — see the Poisonings section on Page 3.
- ☐ **Poliomyelitis***
- ☐ **Psittacosis**
- ☐ **Q fever***
- ☐ **Rabies and exposure to rabies*** — see **animal bites** in the Environmental Conditions section on Page 3.
- ☐ **Respiratory syncytial virus, pediatric death** (children under 18 years of age)
- ☐ **Ricin poisoning***
- ☐ **Rickettsialpox**
- ☐ **Rocky Mountain spotted fever**
- ☐ **Rubella** (German measles)*
- ☐ **Rubella syndrome, congenital**
- ☐ **Salmonellosis**†
  - Serogroup: _____
  - If due to *Salmonella* Typhi or *Salmonella* Paratyphi, select **typhoid fever** or **paratyphoid fever**.
- ☐ **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 the STI section on Page 4.
- ☐ **Tetanus**
- ☐ **Toxic shock syndrome**
- ☐ **Trachoma**
- ☐ **Transmissible spongiform encephalopathy** (Creutzfeldt-Jakob disease and variants)
  - Testing (e.g., 14-3-3 on CSF, brain biopsy, autopsy, or EEG/MRI) completed: _____
- ☐ **Trichinosis**
- ☐ **Tuberculosis** — see the Tuberculosis (TB) section on Page 3.
- ☐ **Tularemia***
- ☐ **Typhoid fever**†
- ☐ **Vaccinia disease** (adverse events associated with smallpox vaccination)*
- ☐ **Varicella** (not shingles)
- ☐ ***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 to 866-692-3641. † If the case meets any of the risk group criteria on this page, report immediately to 866-692-3641.**

Risk Groups for Disease Exposure or Transmission

Complete this section for diseases marked with a dagger (†). If the case meets any criteria, report it immediately to 866-692-3641.

Patient works in (check all that apply):
☐ Child care ☐ Food service ☐ Health care facility ☐ Correctional facility ☐ Long-term care facility or nursing home ☐ Position with routine animal contact
☐ Clinical or research laboratory ☐ Unknown ☐ Other (specify): _____

Name of workplaces: _____ Location of workplaces: _____ Type of work: _____

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

Name of facilities: _____ Location of facilities: _____

Patient Last Name	First Name	Medical Record Number

Environmental Conditions

☐ **Animal bites**

☐ **Exposure to rabies***

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

Animal species: _____

Breed: _____ Colors: _____

☐ Owned ☐ Stray ☐ Unknown

Owner's name: _____

Address: _____

City, State, ZIP code: _____

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 or immersion in liquid.

Drowning location: _____

Outcome: ☐ Death ☐ Morbidity ☐ No morbidity

☐ **Window falls**

For falls from windows of buildings with three or more dwellings by children age 16 and younger, report by calling 646-632-6023 or completing the Child Window Fall Reporting Form.

Poisonings

Route of Exposure

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

Chemical

☐ **Lead**

For people age 16 and older, indicate:
Employer:
Employer phone: _____

☐ **Carbon monoxide***

Source: ☐ Furnace or boiler ☐ Generator ☐ Vehicle ☐ Other (specify): _____

☐ **Arsenic** ☐ **Cadmium**
☐ **Mercury** ☐ **Pesticide**
☐ **Other** (specify): _____

Quantity

☐ Milliliter (mL): _____
☐ Mouthful: _____
☐ Sip: _____
☐ Tablespoon:
☐ Tab, pill, or cap:
☐ Taste, lick, or drop: _____
☐ Teaspoon: _____
☐ Unknown

Date and Time of Exposure

_____
____ ____ ☐ a.m. ☐ p.m.

Reason and Setting

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

Intentional:
☐ Suspected suicide
☐ Misuse
☐ Abuse
☐ Unknown
Other:
☐ Contamination or tampering
☐ Malicious
☐ Withdrawal
Adverse reaction:
☐ Drug
☐ Food
☐ Other
☐ Unknown

Symptom Assessment (Check all that apply.)

☐ None
☐ Nausea, vomiting, or diarrhea
☐ Lethargic, stupor, or coma
☐ Agitated
☐ Hypertensive
☐ Hypotensive
☐ Tachycardia
☐ Brachycardia
☐ Seizure
☐ Electrolyte abnormalities
☐ Cough or shortness of breath
☐ Ocular irritation
☐ Skin irritation
☐ Unknown
☐ Other (specify): _____

Provider Treatment

☐ No therapy required
☐ Oral fluids
☐ Emesis
☐ Lavage
☐ Activated charcoal
☐ Cathartic
☐ Chelation
☐ Insect sting management
☐ Irrigated eye
☐ Oxygen
☐ Naloxone
☐ 50% dextrose or thiamine
☐ Alkalinize urine
☐ N-acetylcysteine (mucromyst)
☐ Other (specify): _____

Specimen Source

☐ Capillary ☐ Venous ☐ Urine
☐ Other (specify):

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's status at time of reporting:
☐ Under 5 years old with LTBI
☐ TB suspect or case

Indicate all sites of disease for TB suspect or case:
☐ Pulmonary
☐ Lymphatic
☐ Bone or joint
☐ Soft tissue or muscles
☐ Peritoneal
☐ Meningeal
☐ Genitourinary
☐ Gastrointestinal
☐ Other (specify): _____

Collection date: _____ ☐ Unknown

Laboratory Results

Specimen number: _____ ☐ Unknown

Specimen source:
☐ Sputum
☐ Tracheal aspirate
☐ Bronchial fluid or bronchoalveolar lavage
☐ Lymph node
☐ Lung tissue
☐ Pleural fluid
☐ Pleura
☐ Blood
☐ Urine
☐ Other (specify): _____

AFB Smear

☐ Positive
Smear grade:
☐ 1+ (rare) ☐ Suspicious
☐ 3+ (moderate) ☐ 2+ (few) ☐ 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:

Mycobacterium TB complex culture:
☐ Positive ☐ Negative
☐ Pending ☐ Contaminated
☐ Not done ☐ Unknown

Pathology consistent with TB:
☐ Yes ☐ No ☐ Unknown
☐ 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 ☐ Pelvis
☐ Abdomen ☐ Spine
☐ Head ☐ Other (specify): _____
☐ Unknown
☐ Neck

☐ 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 or PPD)
☐ QuantiFERON-TB Gold Plus (QFT-Plus)
☐ T-SPOT.TB
☐ Other (specify): _____

☐ Positive ☐ Negative ☐ Unknown
☐ Indeterminate ☐ Borderline

Induration: _____ mm

Treatment

On anti-TBD medications: ☐ Yes ☐ No ☐ Unknown

Please complete for each medication:

Medication	Dose (mg)	Frequency per 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 Page 4.

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Patient Last Name	First Name	Medical Record Number

Sexually Transmitted Infections

For All Sexually Transmitted Infections Reports

As of the date of this report:

Were any of the patient's sex partners notified of possible exposure to a sexually transmitted infections (STI)? (Check all that apply.)
- ☐ Yes, our office notified the partner(s).
- ☐ Yes, the patient was asked to notify their partner(s).
- ☐ No
- ☐ Unknown

Did you provide treatment for any of the patient's partners? (Check all that apply.)
- ☐ Yes, I saw sex partner(s) in my office.
- ☐ Yes, I gave extra medication for _____ (number) partner(s).
- ☐ Yes, I wrote a prescription for _____ (number) partner(s).
- ☐ Yes, some other way (specify): _____
- ☐ No ☐ Unknown

Is the patient on pre-exposure prophylaxis (PrEP) to prevent HIV infection?
- ☐ Yes, the patient started PrEP at the time of current STI diagnosis.
- ☐ Yes, the patient was already on PrEP at the time of current STI diagnosis.
- ☐ No
- ☐ Unknown

Indicate the gender of all sexual partners in the past year (check all that apply):
☐ Woman ☐ Man ☐ Unknown ☐ Transgender woman ☐ Transgender man

Did you prescribe doxycycline post-exposure prophylaxis (doxy PEP) during this patient encounter to prevent STIs?
☐ Yes ☐ No ☐ Unknown

☐ **Chancroid**

Specify type of specimen:
☐ Penile ☐ Vaginal ☐ Endocervical ☐ Anorectal ☐ Oropharyngeal
☐ Other (specify): _____
Specimen collection date: _____
Treatment: _____
Treatment date: _____ ☐ Unknown

☐ **Chlamydia (CT)**

Specify type of specimen:
☐ Endocervical ☐ Urethral ☐ Anorectal ☐ Oropharyngeal ☐ Urine
☐ Other (specify): _____
Specify test type:
☐ Culture ☐ Nucleic Acid Amplification ☐ Nucleic acid hybridization ☐ EIA ☐ DFA
☐ Other (specify): _____
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 ☐ EIA ☐ DFA
☐ Other (specify): _____
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 (specify): _____
Specimen collection date: _____
Treatment: _____
Treatment date: ☐ Unknown

☐ **Lymphogranuloma venereum**

Clinical presentation (check all that apply):
☐ Proctitis ☐ Lymphadenopathy ☐ Buboe ☐ Skin lesion
☐ Other (specify): _____
Specimen collection date: _____
Treatment: _____
Treatment date: _____ ☐ Unknown

☐ **Herpes, neonatal**

Herpes simplex virus infection in infants age 60 days and younger.
☐ Clinical diagnosis
☐ Lab confirmed diagnosis
☐ Culture ☐ PCR
☐ Other (specify): _____
Herpes type: ☐ Type 1 ☐ Type 2 ☐ Not typed
Clinical syndrome (check all that apply):
☐ Skin, eye, or mucous membrane infection
☐ CNS involvement
☐ Disseminated disease
Herpes lesions present?
☐ Yes, anatomic site: _____
☐ No ☐ Unknown
Specimen collection date: _____
Treatment for infant: _____
Treatment date: _____ ☐ Unknown

☐ **For neonatal herpes and congenital syphilis:**

Parent who delivered this infant:
First name: _____
Last name:
Phone: _____
Date of birth: _____
Address: _____
City: _____ ZIP code: _____
Birth hospital: _____
Labor and delivery medical record number:
_____

☐ **For congenital syphilis:**

Vital status:
☐ Alive ☐ Stillborn ☐ Born alive, then died ☐ Unknown
Birth weight in grams:
_____
Estimated gestational age (weeks):
_____

For congenital syphilis (continued):

Did the infant or child have any signs of congenital syphilis? (Check all that apply.)
☐ Condyloma lata ☐ Snuffles ☐ Syphilitic skin rash ☐ Hepatosplenomegaly ☐ Jaundice due to syphilitic hepatitis ☐ Pseudoparalysis ☐ Edema ☐ Other (specify): _____

Did the infant or child have long bone X-rays?
☐ X-rays show changes consistent with congenital syphilis.
☐ X-rays were performed, but no signs of congenital syphilis.
☐ X-rays were not performed.
☐ Unknown

Did the infant or child receive treatment?
☐ Yes, with aqueous or procaine penicillin for 10 days.
☐ Yes, with a single intramuscular dose of benzathine penicillin G.
☐ Yes, with other treatment (specify):
☐ No treatment
☐ Unknown

☐ **Syphilis§**

Stage:
☐ Congenital
☐ Primary, chancre present (check all that apply): ☐ Penile ☐ Vaginal ☐ Endocervical ☐ Anorectal ☐ Oropharyngeal
☐ Other (specify): _____
☐ Secondary (check all that apply): ☐ Alopecia ☐ Condylomata ☐ Mucous patches ☐ Rash
☐ Other (specify): _____
☐ Early latent (no symptoms, infection of ≤ 1 year)
☐ Late latent (no symptoms, infection of > 1 year)
☐ Tertiary, gumma, or cardiovascular
Neurological symptoms present?
☐ Yes ☐ No ☐ Unknown
Ocular symptoms present?
☐ Yes ☐ No ☐ Unknown
Otologic symptoms present?
☐ Yes ☐ No ☐ Unknown
Treatment (list medication and dosage):
_____
Treatment date: _____
☐ Unknown

Syphilis (continued):

Syphilis test types (check all that apply:)

1. Serologic tests for syphilis

A. Nontreponemal test
☐ RPR ☐ Reactive ☐ Nonreactive
Titer: _____
☐ VDRL ☐ Reactive ☐ Nonreactive
Titer: _____
Specimen collection date: _____

B. Treponemal test
☐ TP-PA/MHA-TP ☐ Reactive ☐ Nonreactive
☐ FTA ☐ Reactive ☐ Nonreactive
☐ Treponemal IgG ☐ Reactive ☐ Nonreactive
Specimen collection date: _____

2. Cerebrospinal fluid tests
☐ CSF VDRL ☐ Reactive ☐ Nonreactive
Titer: _____
☐ CSF FTA ☐ Reactive ☐ Nonreactive
☐ 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
Nucleic Acid Amplification Test
☐ Positive ☐ Negative
Immunohistochemistry or special stain
☐ Positive ☐ Negative
Direct fluorescence antibody
☐ Positive ☐ Negative
☐ Other test: _____ Result: _____
Specimen collection date: _____

‡ For uncomplicated gonococcal infection of the cervix, urethra, rectum, or pharynx among adults and adolescents, administer 500 mg of ceftriaxone intramuscularly in a single dose for people weighing < 150 kg, or 1 g of ceftriaxone for people weighing ≥ 150 kg. If chlamydial infection has not been excluded, treat for chlamydia with 100 mg of doxycycline orally two times per day for seven days. During pregnancy, administer 1 g of azithromycin orally in a single dose.

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

Comments