MEDICAL FORM

CITY OF SAN ANTONIO — TEXAS

METROPOLITAN HEALTH DISTRICT

This section to be completed by referring provider.

NOTE: This form is intended for provider-to-provider communication purposes only.

Primary and secondary syphilis cases must be reported by phone within 1 workday. All other stages, including congenital syphilis must be reported within 1 week.

STI/HIV Reporting Line: 210-207-8831 **Fax**: 210-207-2116

Syphilis titer and treatment lookup: 210-207-8827 (M-F)
Evenings, Weekends, Holidays: 210-207-8876

***Patients with known penicillin allergy require de-sensitization in a hospital setting and cannot be treated by Metro Health.**

Date:	Provider and/or Practice name:
Address:	Phone:
Patient Name:	
Patient DOB:	
LMP:	EDC:

Syphilis Staging

Please indicate below the identified syphilis stage at the time of diagnosis

☐	**Primary** (chancre/ulcer present)
☐	**Secondary** (rash, condylomata lata, mucous patches, alopecia, lymphadenopathy, etc.)
☐	**Early Latent** (no clinical findings on exam **with positive serology, AND either:** ☐ **negative syphilis test in last 12 months; OR** ☐ **4-fold increase in titer**
☐	**Late Latent/Unknown duration** (no clinical findings on exam **with positive serology, and no negative syphilis test in the last 12 months**)

Findings / Remarks (include titers with dates):

_____

_____

_____

This section to be completed by Metro Health Staff Only

Syphilis Staging

☐	**Primary** (chancre/ulcer present)
☐	**Secondary** (rash, condylomata lata, mucous patches, alopecia, lymphadenopathy, etc.)
☐	**Early Latent** (no clinical findings on exam **with positive serology, AND either:** ☐ **negative syphilis test in last 12 months; OR** ☐ **4-fold increase in titer**
☐	**Late Latent/Unknown duration** (no clinical findings on exam **with positive serology, and no negative syphilis test in the last 12 months**)

Findings / Remarks: _____

_____

Treatment plan:

Bicillin (benzathine penicillin G)

☐ Bicillin 2.4MU IM x 1 dose

☐ Bicillin 2.4MU IM x 3 doses

Dose 1 **Administered date:**	
Dose 2 due date:	**Administered date:**
Dose 3 due date:	**Administered date:**
Follow-up testing: 8 weeks after treatment if under 24 weeks' gestation. Otherwise at 28 weeks and at delivery.	

Metro Health Clinic Staff completing form:

Name:_____ Credentials:_____

Signature: _____ Date: _____

CITY OF SAN ANTONIO TEXAS

METROPOLITAN HEALTH DISTRICT

512 E. Highland Blvd San Antonio, Texas 78210 PHONE (210) 207-8859 FAX (210) 207-2116