Lambton Public Health

Infection Treatment Reporting Form

Health Care Provider:		
Phone:		**Fax:**
Client Demographics		
Legal Name:	Date of Birth:	
Address:	Phone:	
Testing Details		
Date of Testing:	Date of Diagnosis:	
Reason for testing: ☐ Routine ☐ Prenatal ☐ Contact ☐ Follow-up Serology ☐ Other (specify)		
Symptomatic: ☐	If yes, specify:	Onset Date:
Pregnancy Status		
☐ N/A ☐ Pregnant ☐ Non-Pregnant ☐ unknown	Trimester: ☐ 1st ☐ 2nd ☐ 3rd	LMP:
Staging &Treatment Details		
SYPHILIS STAGE (<1 yr): ☐ **PRIMARY** ☐ **SECONDARY** ☐ **EARLY LATENT**		
Preferred Treatment ☐ **Penicillin G** (Bicillin L-A) 2.4 million units IM, **single dose** **Treatment Date:**	**Alternative Treatment/ Penicillin-Allergy** ☐ **Doxycycline** 100 mg PO BID for **14 days** **Treatment Date:**	
☐ Advised/booked for recommended follow-up **serology at 3, 6, 12 months post treatment** (☐ HIV co-infection: at 3, 6, 12, 24 months and then yearly thereafter; ☐ Pregnancy: monthly until delivery and then 1, 3, 6, 12 months post treatment)		
SYPHILIS STAGE (>1 yr): ☐ LATE LATENT ☐ LATENT OF UNKNOWN DURATION		
Preferred Treatment ☐ **Penicillin G** (Bicillin L-A) 2.4 million units IM, **weekly x 3 doses** **Treatment Date:** **Dose #1:** **Dose #2:** **Dose #3:**	**Alternative Treatment/ Penicillin-Allergy** ☐ **Doxycycline** 100 mg PO BID for **28 days** **Treatment Date:**	
☐ Advised/booked for recommended follow-up **serology at 12, 24 months post treatment** (☐ HIV co-infection: at 3, 6, 12, 24 months and then yearly thereafter; ☐ Pregnancy: At delivery and then 12, 24 months)		
SYPHILIS STAGE: ☐ NEUROSYPHILIS ☐ CONGENITAL ☐ OTHER (please specify)		
☐ **Treatment (please specify):** **Treatment Date:** Follow-up serology advised/booked (specify):		
☐ Advised/booked for recommend follow up serology for neurosyphilis at 6, 12, 24 months post treatment		
Education & Referrals		
☐ Advised to abstain from sexual contact (ALL TYPES) for 7 days after treatment is completed (i.e. after completion of a multiple-dose or single-dose treatment)		
☐ Contacts notified by Case		
☐ Health Teaching completed by Health Care Provider		
☐ Referral, if made please indicate:		
Health Care Provider Signature: Date: Health Care Provider name (please print):		
Documentation Key ☑=Yes ☒=No ☐=Not asked/reviewed		