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 testing done
(☐ 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