



LOS ANGELES COUNTY STD PROGRAM SYPHILIS LABORATORY REPORT



DATE OF REPORT - - REPORT STATUS New Update REPORT DONE BY

1 PATIENT

PATIENT'S LAST NAME FIRST NAME M.I.

PATIENT'S STREET ADDRESS APT/UNIT NO.

CITY/TOWN STATE ZIP CODE

AREA CODE DAY TELEPHONE NUMBER GENDER: Male Female Transgender (M to F) Transgender (F to M) Unknown or Refused

AREA CODE EVENING TELEPHONE NUMBER PREGNANT: Yes No Unknown POSTPARTUM: Yes No Unknown

Birth Date - - AGE: RACE (X all that apply): White Black or African American Native American or Alaska Native Asian or Asian American Native Hawaiian or Pacific Islander Unknown Refused Other:

2 PROVIDER

DOCTOR'S LAST NAME DOCTOR'S FIRST NAME M.I.

FACILITY/CLINIC NAME

FACILITY STREET ADDRESS SUITE/UNIT NO.

CITY/TOWN STATE ZIP CODE

AREA CODE TELEPHONE NUMBER AREA CODE FAX NUMBER

For HIV REPORTING:
Call (213) 351-8516 or visit publichealth.lacounty.gov/hiv/

3 LABORATORY

LABORATORY'S NAME

LABORATORY'S STREET ADDRESS

CITY/TOWN STATE ZIP CODE

AREA CODE TELEPHONE NUMBER AREA CODE FAX NUMBER

4 SYPHILIS TEST RESULT

TEST NAME: RPR Titer VDRL Titer TP- PA (Serodia) FTA - ABS MHA - TP RPR Qualitative Other (Specify)

TEST RESULT: Reactive - Titer 1: Reactive Non-Reactive Weakly Reactive Other (Specify)

SPECIMEN TYPE: BLOOD CSF Other (Specify)

Spec. Coll. Date (MM-DD-YY): - -

Test Date (MM-DD-YY): - -

Specimen ID #:

Date reported (MM-DD-YY): - -

Date Received (MM-DD-YY): (For Office Use Only) - -

5 REFERENCE LABORATORY

REFERENCE LABORATORY'S NAME (If specimen was sent for further testing from original lab to reference lab, reference lab info required in addition to the above information)

REFERENCE LABORATORY'S STREET ADDRESS

CITY/TOWN STATE ZIP CODE

AREA CODE TELEPHONE NUMBER AREA CODE FAX NUMBER

TEST NAME: RPR Titer TP- PA (Serodia) FTA - ABS MHA - TP

TEST RESULT: Reactive - Titer 1: Reactive Non-Reactive Weakly Reactive Other (Specify)

Test Date (MM-DD-YY): - -

Date reported (MM-DD-YY): - -