

West Virginia Department of Health and Human Resources
Bureau for Public Health
Office of Epidemiology and Prevention Services
Division of STD, HIV, Hepatitis and Tuberculosis
304-558-2195

Rapid Syphilis Result Report Form

Session Date: ____ / ____ / ____

Client Name and Contact Information

First and Last Name:		Birthdate:	____ / ____ / ____
Address:			
City/State/Zip:			
Home Phone: (____) _____-_____	Cell Phone: (____) _____-_____	Email:	

Client Demographics

Ethnicity:	Race: <i>(select all that apply)</i>	Assigned Sex at Birth:	Current Gender Identity:
<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Don't Know <input type="checkbox"/> Declined to Answer	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Not Specified <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Don't Know <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to Answer	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Unspecified <input type="checkbox"/> Another Gender <input type="checkbox"/> Declined to Answer

Client Medical Information

Does the patient report a history of syphilis?	Does the patient currently have symptoms?	Has the patient been tested in the last 12 months?	Is the patient currently pregnant?	Has treatment been given or scheduled at this time?	Has a blood draw been done to verify this result?	Has the patient been notified of their test result?
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list symptoms</i> _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Test Information

Test Type:	Date:	Lot #:	Expiration Date:	Times:	Rapid Test RESULTS
<input type="checkbox"/> SHC <input type="checkbox"/> Chembio <input type="checkbox"/> Other	____ / ____ / ____	_____	____ / ____ / ____	Test Start Time: _____ Test Read Time: _____	<input type="checkbox"/> Positive <input type="checkbox"/> Preliminary Positive <input type="checkbox"/> Invalid

Facility Information

Reporting Facility:			
Tester Name:	Tester Signature:		

Please report all syphilis test results to:

STD Surveillance Unit
Fax: 304-558-478
Email: wvstd@wv.gov

