

Syphilis Treatment Form

Syphilis is a reportable infection. Complete this form with the patient and treatment details, and FAX according to your client's address of residence:

If your **client resides** in the geographical area for the following:

- Fraser Health Authority
- Interior Health Authority
- Island Health Authority
- Northern Health Authority

Fax to:
(604) 707-5604

If your client resides in **Vancouver Coastal Health Authority (VCH):**

Fax to:
(604) 731-2756

Patient Information

Name	<i>Surname</i>	<i>Given Name(s)</i>	Date of Birth	<i>(yyyy/mm/dd)</i>
Phone			PHN	
E-mail				

Bicillin® L-A Dose*	Date of Administration	Comments	
1	<i>(yyyy/mm/dd)</i>	Was the patient given treatment as a contact to a syphilis infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did the patient have any of the following symptoms at time of treatment? <input type="checkbox"/> Chancre <input type="checkbox"/> Rash <input type="checkbox"/> Other _____
2	<i>(yyyy/mm/dd)</i>		
3	<i>(yyyy/mm/dd)</i>	Was serology ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No	

*Bicillin® L-A (Penicillin G Benzathine): 2.4 million units intramuscularly per dose

Healthcare Provider Information

Provider Name	<i>Surname</i>	<i>Given Name(s)</i>
Clinic	Clinic Name: _____	
	Address: _____	
	Phone: _____ Fax: _____	
	Type (select below): <input type="checkbox"/> Acute Care, including ED and in-patient <input type="checkbox"/> UPCC <input type="checkbox"/> Corrections <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Outreach <input type="checkbox"/> Substance Use Services <input type="checkbox"/> First Nations Health Centre, Nursing Station or Indigenous Primary Care Centre <input type="checkbox"/> Primary Care <input type="checkbox"/> Public Health Unit <input type="checkbox"/> STI Clinic <input type="checkbox"/> Other: _____	

Need more copies? <http://www.bccdc.ca/health-professionals/professional-resources/pharmacy>