MEDICAL RECORD — SEROLOGY RECORD

SECTION I - HISTORY OF PRESENT INFECTION

SOURCE OF REFERRAL				INCIDENT TO			
☐	VOLUNTARY	☐	PHYSICAL INSPECTION	☐	HOSPITALIZATION	☐	PRENATAL
☐	CONTACT REPORT	☐	BLOOD TRANSFUSION	☐	PREMARITAL	☐	OTHER *(Specify)*:

DATES			DIAGNOSTIC CRITERIA *(Enter results of tests)*	
ONSET SYMPTOMS	REQUESTED TREATMENT	DIAGNOSIS ESTABLISHED	DARKFIELD	S.T.S.

DIAGNOSIS *(Include stage and diagnosis No.)*

SPINAL FLUID *(If indicated)*

OTHER *(List)*

CLINICAL DATA *(Include chief complaint, physical findings - eye, cardiovascular and nervous system, even in early syphilis)*

STD CONTACT FORM SERIAL NUMBERS

RECOMMENDED TREATMENT

RECOMMENDED FOLLOW-UP

SIGNATURE OF PHYSICIAN	NAME OF PHYSICIAN	DATE

I HAVE BEEN INFORMED BY THE MEDICAL OFFICER THAT I HAVE BEEN DIAGNOSED AS HAVING SEXUALLY TRANSMITTED DISEASE AS INDICATED ABOVE; THE NATURE OF THIS DISEASE HAS BEEN EXPLAINED TO ME; I UNDERSTAND THAT MY COOPERATION IS NECESSARY IN THE TREATMENT AND PROLONGED OBSERVATION *(Including certain prescribed tests)* FOR THE CARE OF THIS DISEASE. DISCLOSURE OF THIS INFORMATION IS REQUIRED BY LAW.

SIGNATURE OF PATIENT	DATE

SECTION II - HISTORY OF PAST SEXUALLY TRANSMITTED INFECTIONS OR TREATMENTS

	DATE	DISEASE *(Give stage)*	PRIOR TO FEDERAL SERVICE		TREATMENT *(Give type, amount and dates)*	TREATING AGENCY	PLACE *(Institution and City)*
			YES	NO			
1							
2							
3							

SECTION III - TREATMENT

NO.	TREATMENT	DATE STARTED	DATE ENDED	SIGNATURE OF PHYSICIAN
1				
2				
3				

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER *(SSN or Other)*
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*	REGISTER NO.	WARD NO.

SEROLOGY RECORD
Medical Record

STANDARD FORM 602 (REV. 8-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

SECTION IV - LABORATORY SUMMARY

DARKFIELD EXAMINATION

	DATE	RESULTS	SOURCE OF SPECIMEN	LABORATORY	NAME OF CONFIRMING OFFICER
1					
2					

NONSPECIFIC TREPONENAL TESTS (VDRL, RPR, ART)

	DATE	TYPE	RESULT *(Include titer value)*	LABORATORY		DATE	TYPE	RESULT *(Include titer value)*	LABORATORY
1					4				
2					5				
3					6				

SPECIFIC TREPONEMAL TESTS (FTA-ABS, MHA-TP, TPHA, TPI)

	DATE	TEST TYPE	RESULTS
1			
2			

SPINAL FLUID EXAMINATIONS

	DATE	CELLS	TOTAL PROTEIN	NONSPECIFIC AND/OR SPECIFIC TESTS *(Including titer)*	LABORATORY WHERE DONE
1					
2					

SECTION V - EVALUATION OF THERAPY

	DATE	FACILITY WHERE EVALUATED	RESULT		DATE OF RETREATMENT	PHYSICIAN'S SIGNATURE
			SATISFACTORY*	UNSATISFACTORY**		
1						
2						
3						

* Satisfactory result cannot be reported without normal spinal fluid findings.

** Specify: Infectious Relapse: Sero-Relapse, Neuro-Relapse, Incomplete data on Spinal Fluid, Other *(Specify)*

REASON FOR INCOMPLETE FOLLOW-UP		PATIENT'S HOME ADDRESS ON SEPARATION		
DATE	PLACE	STREET ADDRESS		
TYPE OF SEPARATION	AUTHORITY FOR DISCHARGE	CITY	STATE	ZIP CODE
CIVILIAN HEALTH DEPARTMENT TO WHICH CASE RESUME WAS SENT		REINFECTION *(Give date new record was opened)*		

REMARKS *(Include significant posttreatment clinical findings)*

SECTION VI - MEDICAL OFFICER CLOSING THIS RECORD

NAME *(Typed or printed)*	SIGNATURE	STATION	DATE

SECTION VII - MEDICAL OFFICER SENDING ABSTRACT TO DEPARTMENT OF VETERANS AFFAIRS ON DISCHARGE

NAME *(Typed or printed)*	SIGNATURE	STATION	DATE