Date:

To:	**CDPH STD ICCR**	**From:**	
Fax:	**916-440-5348**	**Fax:**	
Phone:	**916-552-9811**	**Phone:**	

CONGENITAL SYPHILIS CASE # REQUEST FORM

Infant's CalREDIE #: _____

Infant's Name (last, first): _____

Date of Delivery: _____

Sex: ☐ Male ☐ Female

City of Residence: _____

Jurisdiction of Residence: _____

Jurisdiction Responsible: _____

Date Reported to Jurisdiction: _____

Reporting Source: _____

Mother's CalREDIE #: _____

Mother's Name (last, first): _____

Mother's DOB: _____

Race/Ethnicity: _____