CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE REPORT

PATIENT DATA

LAST NAME | FIRST NAME | INIT D

ADDRESS | TELEPHONE ( )

CITY / TOWN | STATE | ZIP CODE

REASON FOR EXAM: (CHECK ONE)
- ☐ Symptomatic
- ☐ Routine Exam—No Symptoms
- ☐ Exposed to Infection

DATE OF DIAGNOSIS: MO | DAY | YR

ETHNICITY: H | Non-His. | U

RACE - Check all that apply: W | B | AI/AN | A | NH/OPI | O | U

SEX: M | F

DATE OF BIRTH

GENDER OF SEX PARTNERS: M | F | Both | U

RACE: W—White; B—Black; AI—American Indian / AN—Alaskan Native; A—Asian; NHOPI—Native Hawaiian/Other Pacfic Islander; O—Other; U—Unknown

DIAGNOSIS-DISEASE

Instructions

PARTNER MANAGEMENT PLAN

✓ **Select method of ensuring partner treatment**

1. ☐ Health Department to assume responsibility for partner treatment.

HEALTH DEPARTMENT ASSISTANCE ONLY RECOMMENDED IF:

- Patient has had 2 or more sex partners in the last 60 days, **or**
- Patient does not think he/she will have sex again with sex partners from the last 60 days, **or**
- Patient is unable or unwilling to contact one or more partner, **or**
- Patient is a man who has sex with other men.

2. ☐ Provider will ensure all partners treated **(FREE medications available)**. Indicate number to be treated(_____)

3. ☐ All partners have been treated. Indicate number treated(_____)

GONORRHEA (lab confirmed)

DIAGNOSIS - ✓ only one	SITE(S) - ✓ all that apply	TREATMENT - ✓ all given/presc.
☐ Asymptomatic	☐ Cervix	☐ Cefpodoxime ☐ Ceftriaxone
☐ Symptomatic - Uncomplicated	☐ Urethra	☐ Doxycycline ☐ Azithromycin
☐ Pelvic Inflammatory Disease	☐ Urine	☐ Levofloxacin* ☐ Ciprofloxacin*
☐ Ophthalmia	☐ Rectum	☐ Cefixime ☐ Other
☐ Disseminated	☐ Pharynx	Other, specify_____
☐ Other Complications:_____	☐ Ocular	*Quinlolones not recommended as first choice for GC treatment; see treatment guldelines.
DATE TESTED _____	☐ Other:_____	DATE RX_____

CHLAMYDIA TRACHOMATIS (lab confirmed)

DIAGNOSIS - ✓ only one	SITE(S) - ✓ all that apply	TREATMENT - ✓ all given/presc.
☐ Asymptomatic	☐ Cervix	☐ Azithromycin
☐ Symptomatic - Uncomplicated	☐ Urethra	☐ Doxycycline
☐ Pelvic Inflammatory Disease	☐ Urine	☐ Erythromycin
☐ Ophthalmia	☐ Rectum	☐ Ofloxacin
☐ Other Complications:	☐ Pharynx	☐ Levofloxacin
_____	☐ Ocular	☐ Other_____
DATE TESTED _____	☐ Other	DATE RX_____

DIAGNOSING CLINICIAN | PERSON COMPLETING REPORT

FACILITY NAME | ADDRESS

CITY | STATE | TELEPHONE ( )

SYPHILIS
- ☐ Primary (Chancre, etc)
- ☐ Secondary (Rash, etc)
- ☐ Early Latent (<1 yr)
- ☐ Late Latent (>1 yr)
- ☐ Congenital
- ☐ Neurosyphilis
- ☐ Late

RX GIVEN_____

_____

DATE RX _____

HERPES SIMPLEX
- ☐ Genital (Initial infection only)
- ☐ Neonatal

Laboratory Confirmation ☐ Yes ☐ No

OTHER
- ☐ Chancroid
- ☐ Granuloma Inguinale
- ☐ Lymphogranuloma Venereum

☐ Need Additional Case Report Forms

STATE OF WASHINGTON SEXUALLY TRANSMITTED DISEASE SERVICES
P.O. BOX 47842, OLYMPIA, WA 98504-7842

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