Complete This Form for Chlamydia, Gonorrhea or Syphilis

CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE RECORD

PATIENT INFORMATION

⇨Fill in ALL text fields and mark variables for complete demographic information as required by CDC.

Name:			DOB:
Address:			Phone: Home Cell
City:	COUNTY of RESIDENCE:	STATE, if not MT:	Zip:
Age:	Sex: M ☐ F ☐	Race: White ☐ American Indian ☐ Black ☐ Asian ☐ Other ☐ Unknown ☐ Ethnicity: Hispanic ☐ Non-Hispanic ☐	

SPECIMEN COLLECTION/CLINICAL DIAGNOSIS

⇨Fill in ALL text fields and mark variables for complete specimen collection information on patient.

Name of Lab Performing Test:	Other: ☐	
Date Lab Specimen Collected:	Test Type:	Test Source:
Date Lab Report Received:	Date Reported to Health Department:	
Patient Diagnosis: Chlamydia ☐ Gonorrhea ☐	Syphilis ⇨	PID: Yes ☐ No ☐ Pregnant: Yes ☐ No ☐
Health Care Provider:		Phone:
Provider's Address:		

PATIENT TREATMENT INFORMATION

⇨Fill in date & mark or fill in text for treatment information at minimum.

Date:	Med: Azithromycin ☐	Dose: 1 gm ☐	Duration: X 1 ☐
Date:	Med:	Dose:	Duration:

CONTACT INTERVIEW

⇨Complete text fields and date this section.

Interviewer:	Date:	Interviewing Agency:

CONTACT INFORMATION

If necessary, please include additional sheets w/patient and contact's name(s).

⇨Please # each additional contact and collect COMPLETE locating information. Fill in text fields and required Disposition Code for each disease.

Contact Name, City, County or State, Phone Number, Place of Employment and Physical Description	Sex	Date of Last Exposure	Test Date	Date of Treatment or Previous Tx	*Disposition Code Required CT/GC/Syphilis
1.	M ☐ F ☐				
2.	M ☐ F ☐				

PATIENT RISK ASSESSMENT INFORMATION

⇨Mark applicable answers and complete patient exposure information within past 12 months as required by CDC.

Had sex w/male?	Yes □	No □	Injection drug use?	Yes □ No □
Had sex w/female?	Yes □	No □	Shared injection equipment?	Yes □ No □
Had sex w/transgender?	Yes □	No □	Injection/Non-Inject drug usage? (Note drugs:)	Yes □ No □
Had sex w/anon. partner?	Yes □	No □	Was patient tested for HIV?	Yes □ No □
Had sex w/o condom?	Yes □	No □		
Had sex w/known IDU?	Yes □	No □	Patient's HIV status?	Pos □ Neg □ Unk □
Had sex while intoxicated/high?	Yes □	No □	Prior STD history?	Yes □ No □
Exchanged drugs/money for sex?	Yes □	No □	Was patient counseled for HIV? Met partners via internet? Was patient screened for?	Yes □ No □ Yes □ No □ Gonorrhea □ Syphilis □
Females-had sex w/known MSM?	Yes □	No □	Partners referred to agencies offering free/reduced-cost testing? Partners referred to agencies offering free/reduced-cost treatment?	Yes □ No □ Yes □ No □
Been incarcerated?	Yes □	No □	Reason for exam?	Symptomatic □ Asymptomatic □ Contact to STD □ Prenatal □

***Disposition Codes**

A. Preventive Treatment
B. Refused Preventive Treatment
C. Infected, Brought to Treatment
D. Infected, not Treated
E. Previously Treated for this Infection
F. Not Infected
G. Insufficient Information to Begin Investigation
H. Unable to Locate
J. Located, Refused Examination
K. Out of Jurisdiction

Comment Section:

Local Health Department Reviewer: New Case ☐ Update of prior report ☐	If out of jurisdiction: Case Referred to DPHHS ☐ County: