Complete this form for ALL patients with positive Chlamydia, Gonorrhea or Syphilis labs

Please fax completed report to FCCHD Communicable Disease Program: 1-866-856-1565

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:**
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:	**Patient Notified?: Yes ☐ No ☐**
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 ☐ *Weeks Gestation:**
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).

Number of contacts 2 months:_____ 12 months:_____

Local Contact Name (Use supplemental/OOJ form as needed)	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? If yes:_____**	**Yes □ No □**
Had sex w/anon. partner?	**Yes □**	**No □**	**Was patient tested for HIV?**	**Yes □ No □ Refused □ Unknown □ Not Asked □**
Had sex w/o condom?	**Yes □**	**No □**	**Patient's HIV status?**	**Pos □ Neg □ Unknown □**
Had sex while intoxicated/high?	**Yes □**	**No □**	**Prior STD history? if yes:_____**	**Yes □ No □**
Exchanged drugs/money for sex?	**Yes □**	**No □**	**Was patient counseled for HIV?** **Met partners via internet?** **Places to meet partners?**	**Yes □ No □** **Yes □ No □**
Females-had sex w/known MSM?	**Yes □**	**No □**	**Was patient screened for?**	**Gonorrhea □ Syphilis □**
Had sex w/known IDU?	**Yes □**	**No □**	**Partners referred to agencies offering free/reduced-cost testing/tx?**	**Yes □ No □**
Been incarcerated?	**Yes □**	**No □**	**Reason for exam?**	**Symptomatic □ Asymptomatic □ Contact to STD □ Prenatal □**

If you have any questions, please call FCCHD Communicable Disease STI Program: 406-758-2163