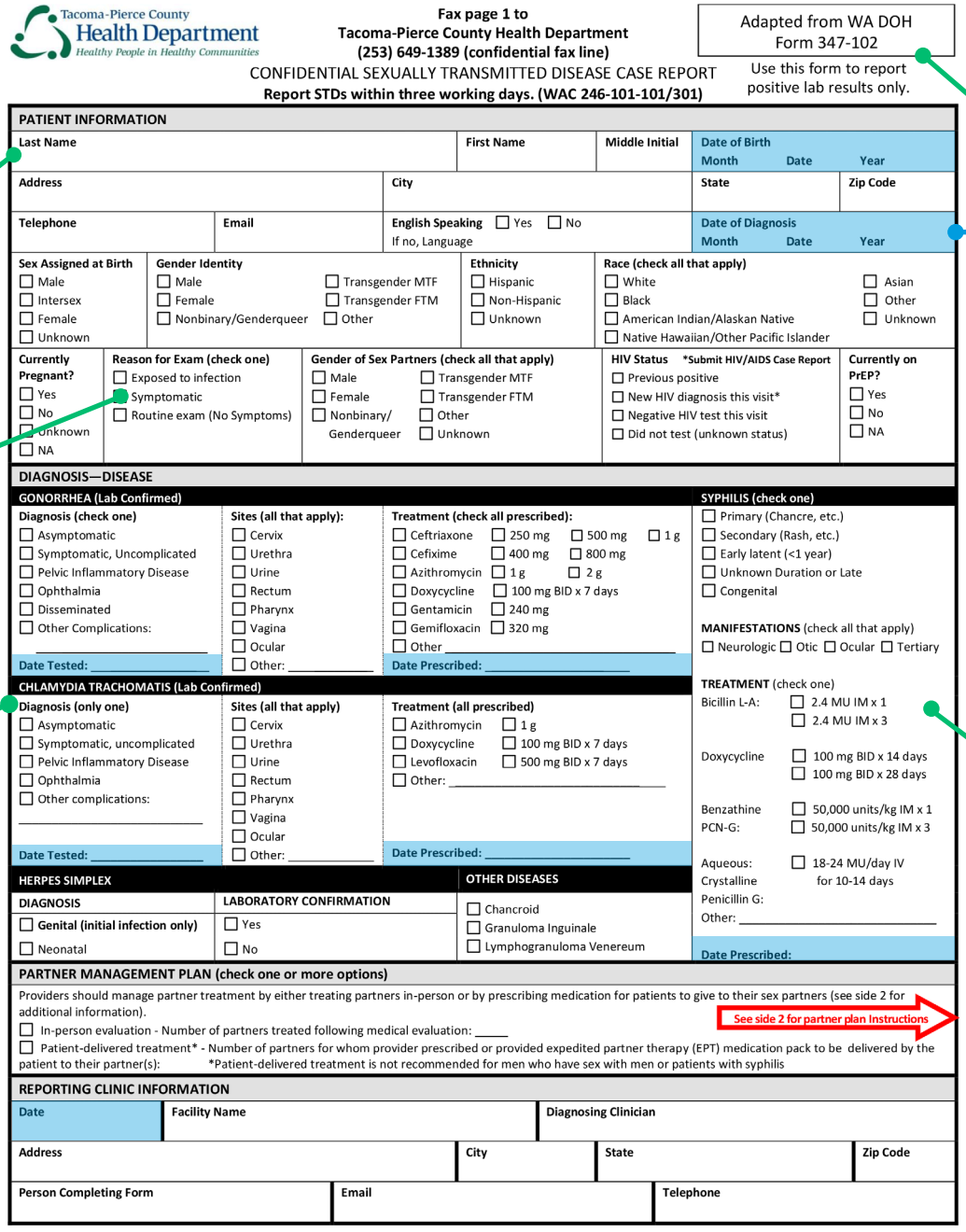
STD Case Report Tips

Tacoma-Pierce County Health Department
Healthy People in Healthy Communities

In addition to patient's legal name, include preferred name.

If reason for exam is "symptomatic" indicate the symptoms in the appropriate disease box.

Report chlamydia in this box. Trichomoniasis is not a reportable condition.



Tacoma-Pierce County Health Department
Healthy People in Healthy Communities

Fax page 1 to
Tacoma-Pierce County Health Department
(253) 649-1389 (confidential fax line)

Adapted from WA DOH Form 347-102

Use this form to report positive lab results only.

CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE REPORT
Report STDs within three working days. (WAC 246-101-101/301)

PATIENT INFORMATION

Last Name | First Name | Middle Initial | Date of Birth Month Date Year

Address | City | State | Zip Code

Telephone | Email | English Speaking ☐ Yes ☐ No If no, Language | Date of Diagnosis Month Date Year

Sex Assigned at Birth
☐ Male ☐ Intersex ☐ Female ☐ Unknown

Gender Identity
☐ Male ☐ Female ☐ Nonbinary/Genderqueer ☐ Transgender MTF ☐ Transgender FTM ☐ Other

Ethnicity
☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Race (check all that apply)
☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ Other ☐ Unknown

Currently Pregnant?
☐ Yes ☐ No ☐ Unknown ☐ NA

Reason for Exam (check one)
☐ Exposed to infection ☐ Symptomatic ☐ Routine exam (No Symptoms)

Gender of Sex Partners (check all that apply)
☐ Male ☐ Female ☐ Nonbinary/ Genderqueer ☐ Transgender MTF ☐ Transgender FTM ☐ Other ☐ Unknown

HIV Status *Submit HIV/AIDS Case Report
☐ Previous positive ☐ New HIV diagnosis this visit* ☐ Negative HIV test this visit ☐ Did not test (unknown status)

Currently on PrEP?
☐ Yes ☐ No ☐ NA

DIAGNOSIS—DISEASE

GONORRHEA (Lab Confirmed)

Diagnosis (check one)
☐ Asymptomatic ☐ Symptomatic, Uncomplicated ☐ Pelvic Inflammatory Disease ☐ Ophthalmia ☐ Disseminated ☐ Other Complications: _____
Date Tested: _____

Sites (all that apply):
☐ Cervix ☐ Urethra ☐ Urine ☐ Rectum ☐ Pharynx ☐ Vagina ☐ Ocular ☐ Other: _____

Treatment (check all prescribed):
☐ Ceftriaxone ☐ 250 mg ☐ 500 mg ☐ 1 g
☐ Cefixime ☐ 400 mg ☐ 800 mg
☐ Azithromycin ☐ 1 g ☐ 2 g
☐ Doxycycline ☐ 100 mg BID x 7 days
☐ Gentamicin ☐ 240 mg
☐ Gemifloxacin ☐ 320 mg
☐ Other _____
Date Prescribed: _____

CHLAMYDIA TRACHOMATIS (Lab Confirmed)

Diagnosis (only one)
☐ Asymptomatic ☐ Symptomatic, uncomplicated ☐ Pelvic Inflammatory Disease ☐ Ophthalmia ☐ Other complications: _____
Date Tested: _____

Sites (all that apply)
☐ Cervix ☐ Urethra ☐ Urine ☐ Rectum ☐ Pharynx ☐ Vagina ☐ Ocular ☐ Other: _____

Treatment (all prescribed)
☐ Azithromycin ☐ 1 g
☐ Doxycycline ☐ 100 mg BID x 7 days
☐ Levofloxacin ☐ 500 mg BID x 7 days
☐ Other: _____
Date Prescribed: _____

HERPES SIMPLEX

DIAGNOSIS
☐ Genital (initial infection only) ☐ Neonatal

LABORATORY CONFIRMATION
☐ Yes ☐ No

OTHER DISEASES
☐ Chancroid ☐ Granuloma Inguinale ☐ Lymphogranuloma Venereum

SYPHILIS (check one)
☐ Primary (Chancre, etc.) ☐ Secondary (Rash, etc.) ☐ Early latent (<1 year) ☐ Unknown Duration or Late ☐ Congenital

MANIFESTATIONS (check all that apply)
☐ Neurologic ☐ Otic ☐ Ocular ☐ Tertiary

TREATMENT (check one)
Bicillin L-A: ☐ 2.4 MU IM x 1 ☐ 2.4 MU IM x 3
Doxycycline ☐ 100 mg BID x 14 days ☐ 100 mg BID x 28 days
Benzathine PCN-G: ☐ 50,000 units/kg IM x 1 ☐ 50,000 units/kg IM x 3
Aqueous Crystalline Penicillin G: ☐ 18-24 MU/day IV for 10-14 days
Other: _____
Date Prescribed:

PARTNER MANAGEMENT PLAN (check one or more options)

Providers should manage partner treatment by either treating partners in-person or by prescribing medication for patients to give to their sex partners (see side 2 for additional information).
See side 2 for partner plan Instructions
☐ In-person evaluation - Number of partners treated following medical evaluation: ____
☐ Patient-delivered treatment* - Number of partners for whom provider prescribed or provided expedited partner therapy (EPT) medication pack to be delivered by the patient to their partner(s): *Patient-delivered treatment is not recommended for men who have sex with men or patients with syphilis

REPORTING CLINIC INFORMATION

Date | Facility Name | Diagnosing Clinician

Address | City | State | Zip Code

Person Completing Form | Email | Telephone

CD-1083-14-001 02/2023

Use this form to report positive results.

Complete all applicable dates.

Complete this section only if treatment was administered.

Rev. Feb. 21, 2023