

**CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE (STD) CASE REPORT**

Report STDs within three working days. (WAC 246-101-101/301)

PATIENT INFORMATION							
Last Name		First Name		Middle Initial	Date of Birth		
Address			City	State	Zip Code		
Email Address			Telephone		Reason for Exam (check one) <input type="checkbox"/> Symptomatic <input type="checkbox"/> Routine exam (no symptoms) <input type="checkbox"/> Exposed to infection		
Date of Diagnosis Month      Day      Year			If Female, Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Race (check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Unknown <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans MTF <input type="checkbox"/> Trans FTM <input type="checkbox"/> Nonbinary/Genderqueer <input type="checkbox"/> Other: _____	Gender of sex partners <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans MTF <input type="checkbox"/> Trans FTM <input type="checkbox"/> Nonbinary/Genderqueer <input type="checkbox"/> Other: _____	HIV Status <input type="checkbox"/> Previous positive <input type="checkbox"/> New HIV diagnosis this visit* <input type="checkbox"/> Negative HIV test this visit <input type="checkbox"/> Did not test <small>*Complete &amp; submit HIV/AIDS Case Report</small>		
DIAGNOSIS—DISEASE							
<b>GONORRHEA (Lab Confirmed)</b> <b>Diagnosis (only one)</b> <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic, uncomplicated <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Ophthalmia <input type="checkbox"/> Disseminated <input type="checkbox"/> Other complications: _____  Date Tested: _____		<b>Sites (all that apply)</b> <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Urine <input type="checkbox"/> Rectum <input type="checkbox"/> Pharynx <input type="checkbox"/> Vagina <input type="checkbox"/> Other: _____		<b>Treatment* (all prescribed)</b> Ceftriaxone <input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> 1 g Cefixime <input type="checkbox"/> 400 mg <input type="checkbox"/> 800 mg Azithromycin <input type="checkbox"/> 1 g <input type="checkbox"/> 2 g Doxycycline <input type="checkbox"/> 100 mg BID x7 days Gentamicin <input type="checkbox"/> 240 mg Gemifloxacin <input type="checkbox"/> 320 mg <input type="checkbox"/> Other: _____ <small>*Recommended treatment: 250mg ceftriaxone, 1g azithromycin</small>  Date Prescribed: _____		<b>SYPHILIS</b> <input type="checkbox"/> Primary (chancere, etc.) <input type="checkbox"/> Secondary (rash, etc.) <input type="checkbox"/> Early latent (less than 1 year) <input type="checkbox"/> Late latent (longer than 1 year) <input type="checkbox"/> Late symptomatic <input type="checkbox"/> Congenital Neurosyphilis <input type="checkbox"/> Yes <input type="checkbox"/> No Date Tested: _____ Prescription Given: _____ Date Prescribed: _____	
<b>CHLAMYDIA TRACHOMATIS (Lab Confirmed)</b> <b>Diagnosis (only one)</b> <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic, uncomplicated <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Ophthalmia <input type="checkbox"/> Other complications: _____  Date Tested: _____		<b>Sites (all that apply)</b> <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Urine <input type="checkbox"/> Rectum <input type="checkbox"/> Pharynx <input type="checkbox"/> Vagina <input type="checkbox"/> Other: _____		<b>Treatment (all prescribed)</b> <input type="checkbox"/> Azithromycin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Doxycycline <input type="checkbox"/> Ofloxacin <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Other: _____  Date Prescribed: _____		<b>HERPES SIMPLEX</b> <input type="checkbox"/> Genital (initial infection only) <input type="checkbox"/> Neonatal <b>Lab Confirmed</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>OTHER</b> <input type="checkbox"/> Chancroid <input type="checkbox"/> Granuloma Inguinale <input type="checkbox"/> Lymphogranuloma Venereum	
PARTNER MANAGEMENT PLAN—Select method of ensuring partner treatment							
1. <input type="checkbox"/> Provider will ensure <b>all</b> partners are treated. Indicate number to be treated ( _____ ). 2. <input type="checkbox"/> All partners have been treated. Indicate number treated ( _____ ). 3. <input type="checkbox"/> Health Department to assume responsibility for partner treatment (if resources permit).							
REPORTING CLINIC INFORMATION							
Date			Diagnosing Clinician				
Facility Name			Person Completing Form				
Address			Telephone				
City	State	Zip Code	Email				



Thank you for reporting a STD. All information will be managed with the strictest confidentiality.

**PRIVILEGED AND CONFIDENTIAL COMMUNICATION:** The information contained in this message is privileged, confidential or otherwise exempt from disclosure and is intended solely for the use of the individual(s) named above. If you are not the intended recipient, you are hereby advised that any dissemination, distribution or copying of this communication is prohibited. If you have received this facsimile in error, please immediately notify the sender by telephone and destroy the original facsimile.

## PARTNER MANAGEMENT PLAN INSTRUCTIONS

### PARTNER TREATMENT

#### Gonorrhea and Chlamydia

- Advise all patients to notify their most recent sex partner and all partners from the 60 days prior to diagnosis.
- All potentially exposed partners should be treated without waiting for laboratory confirmation of infection.
- Attempt to see and treat partners whenever possible. If you plan to have a patient with gonorrhea or chlamydia return to your office or clinic for treatment, ask them to bring a partner with them to be treated at the same time.
- Offer all heterosexual patients medication to give to their sex partners if you cannot otherwise assure their treatment.
  - **Public Health can provide you with FREE medication packs** for your heterosexual patients to give to their sex partner(s). You can also prescribe free medication packs by faxing a prescription to a pharmacy. **Only selected pharmacies have free medication packs.**
  - A **prescription FAX form** and list of pharmacies that stock free medication can be found on the next page.
  - You can order medication packs to stock in your office or clinic by calling MJ McTighe at (206) 744-2345 or faxing an order form to the STD program. Forms and instructions are available at the website indicated above.
- Advise all patients with gonorrhea and all MSM patients that the health department may call them.
- Public Health does not routinely contact heterosexuals with chlamydial infection for purposes of partner notification.

#### Infectious syphilis

- Advise patients to notify their partners from the 90 days prior to onset of symptoms. Depending on the patient's syphilis stage, additional partners may require evaluation and treatment.
- Inform patients that Public Health will contact them to assist with partner treatment.

### OTHER STDS: PARTNER TREATMENT

- Public Health will contact patients reported with HIV, chancroid, granuloma inguinale, or lymphogranuloma venereum
- Public Health does not routinely contact patients with genital herpes.
- Advise patient to notify sex partners and advise them to seek medical care.

## RECOMMENDED REGIMENS FOR ANTIMICROBIALS LISTED ON CASE REPORTS\*

### GONORRHEA—UNCOMPLICATED

Ceftriaxone ..... 250 mg IM as a single dose ..... **PLUS** Azithromycin 1g PO as a single dose

#### Alternatives:

Cefixime ..... 400 mg PO as a single dose ..... **PLUS** Azithromycin 1g PO as a single dose **OR**

#### For beta-lactam allergic patients:

Azithromycin....2g PO as a single dose...**PLUS** Gentamicin 240mg IM OR Gemifloxacin 320mg PO – either as a single dose

### CHLAMYDIA—UNCOMPLICATED

Azithromycin ..... 1g PO as a single dose

#### OR

Doxycycline ..... 100 mg PO BID for 7 days (Preferred for rectal chlamydial infection)

#### Alternatives:

Erythromycin(base).....500 mg PO QID for 7 days **OR**

Ethylsuccinat.....800 mg PO QID for 7 days **OR**

Ofloxacin ..... 300 mg PO BID for 7 days **OR**

Levofloxacin ..... 500 mg PO for 7 days

### SYPHILIS—PRIMARY, SECONDARY OR EARLY LATENT (<1 YEAR)

Benzathine penicillin G ..... 2.4 million units IM in a single dose

### SYPHILIS—LATE LATENT, LATENT OF UNKNOWN DURATION, TERTIARY (NOT NEUROSYPHILIS)

Benzathine penicillin G ..... 2.4 million units IM for 3 doses at 1 week intervals

\* Refer to "STD Diagnostic and Treatment Guidelines" or the Centers for Disease Control and Prevention's (CDC's) website ([www.cdc.gov/std/treatment](http://www.cdc.gov/std/treatment)) for further information on treating pregnant patients, infections of the pharynx, treatment of infants and other details.