

Complete This Side For Gonorrhea, Syphilis, or Chlamydia

CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE RECORD

PATIENT INFORMATION										
Name:						DOB:				
Address:						Phone:				
City:			County:			Zip:				
Age:	Sex:	M	F	Race:	White	Black	American Indian	Asian	Hispanic	Unknown

SPECIMEN COLLECTION/CLINICAL DIAGNOSIS	
Name of Lab Performing Test: MTPHL or :	
Date Lab Specimen Collected:	Date Lab Report Received:
Date Reported to Health Department:	Reporting Source to Health Department:
Patient Diagnosis:	PID: Yes No
Health Care Provider:	Phone:
Provider's Address:	

PATIENT TREATMENT INFORMATION			
Date:	Med:	Dose:	Duration:
Date:	Med:	Dose:	Duration:

CONTACT INTERVIEW	
Interviewer:	Date:
Interviewing Agency:	

CONTACT INFORMATION						
Name of Contact	Sex	Date of Last Exposure	Test Date	Date of Treatment	Disposition Code (See Below)	

ADDITIONAL INFORMATION			
Was patient counseled about HIV risk?	Yes	No	Date if Known:
Was patient tested for HIV?	Yes	No	Date if Known:

DISPOSITION CODES

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

Comments: _____

Local Health Department Reviewer: _____	If out of jurisdiction: Case Referred to DPHHS <input type="checkbox"/> or County <input type="checkbox"/>
<input type="checkbox"/> New Case	<input type="checkbox"/> Update of prior report