

CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE RECORD

PATIENT INFORMATION	⇒ Fill in ALL text fields and <u>mark</u> variables for complete demographic information as required by CDC.
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Name:		DOB:	
Address:		Phone: Home	Cell
City:	COUNTY of RESIDENCE:	STATE, if not MT:	
Age:	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Race: White <input type="checkbox"/> American Indian <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/>	
		Ethnicity: Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/>	

SPECIMEN COLLECTION/CLINICAL DIAGNOSIS	⇒ Fill in ALL text fields and <u>mark</u> variables for complete specimen collection information on patient.
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Name of Lab Performing Test:		Other: <input type="checkbox"/>
Date Lab Specimen Collected:	Test Type:	Test Source:
Date Lab Report Received:	Date Reported to Health Department:	
Patient Diagnosis: Chlamydia <input type="checkbox"/>	Syphilis ⇒	PID: Yes <input type="checkbox"/> No <input type="checkbox"/>
Gonorrhea <input type="checkbox"/>		Pregnant: Yes <input type="checkbox"/> No <input type="checkbox"/>
Health Care Provider:		Phone:
Provider's Address:		

PATIENT TREATMENT INFORMATION	⇒ Fill in date & mark or fill in text for treatment information at minimum.
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Date:	Med: Azithromycin <input type="checkbox"/>	Dose: 1 gm <input type="checkbox"/>	Duration: X 1 <input type="checkbox"/>
Date:	Med:	Dose:	Duration:

CONTACT INTERVIEW	⇒ Complete text fields and date this section.
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Interviewer:	Date:	Interviewing Agency:
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CONTACT INFORMATION <i>If necessary, please include additional sheets w/patient and contact's name(s).</i>	⇒ Please # each additional contact and collect COMPLETE locating information. Fill in text fields and required Disposition Code for each disease.
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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 <input type="checkbox"/> F <input type="checkbox"/>				
2.	M <input type="checkbox"/> F <input type="checkbox"/>				

PATIENT RISK ASSESSMENT INFORMATION	⇒ Mark applicable answers and complete patient exposure information within past 12 months as required by CDC.
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Had sex w/male?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Injection drug use?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Had sex w/female?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Shared injection equipment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Had sex w/transgender?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Injection/Non-Inject drug usage? (Note drugs:)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Had sex w/anon. partner?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Was patient tested for HIV?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Had sex w/o condom?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Patient's HIV status?	Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk <input type="checkbox"/>
Had sex w/known IDU?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Prior STD history?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Had sex while intoxicated/high?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Was patient counseled for HIV?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Exchanged drugs/money for sex?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Met partners via internet?	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Was patient screened for?	Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/>
Females-had sex w/known MSM?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Partners referred to agencies offering free/reduced-cost testing?	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Partners referred to agencies offering free/reduced-cost treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Been incarcerated?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Reason for exam?	Symptomatic <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Contact to STD <input type="checkbox"/> Prenatal <input type="checkbox"/>

*Disposition Codes

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

Comment Section:

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