

CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE RECORD

PATIENT INFORMATION

ENTERED IN MIDIS BY:

Name:		DOB:	
Address:		Phone:	
City:	Zip:	County:	Phone:
Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F IA:	Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	

SPECIMEN COLLECTION/CLINICAL DIAGNOSIS

Date tested:	Test Type/Results::
Diagnosis: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis STAGE:	
Pregnant: Yes No Weeks:	Symptoms:
Prenatal Care: Yes No History syphilis: Yes No	
PID: Yes No	Provider:

PATIENT TREATMENT INFORMATION

Date:	Med: <input type="checkbox"/>	Dosage: <input type="checkbox"/>	Duration: <input type="checkbox"/>
Date:	Med:	Dosage:	Duration:

CONTACT INTERVIEW

Interviewer:	Date:	Interviewing Agency:
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CONTACT INFORMATION If necessary, include additional sheets with patient and contact's name(s). Please # each additional contact and collect COMPLETE locating information. Fill in text fields and required Disposition Code for each disease.

Local Contact Name (use supplemental/OOJ form as needed).	Sex M/F	Date of Last Exposure	Test Date	Date of Tx or Previous Tx	*Disposition Code
1.					
2.					

PATIENT RISK ASSESSMENT INFORMATION Mark applicable answers and complete patient exposure information within past 12 months.

# partners 1 year/2mos.	Yes	No		Yes	No
Had sex w/male? ___/___			Shared injection equipment?		
Had sex w/female? ___/___			Injection/Non-inject drug usage? Note drugs:		
Had sex w/transgender? ___/___			Was patient tested for HIV? <input type="checkbox"/> Refused <input type="checkbox"/> Unknown <input type="checkbox"/> Did not ask		
Had sex w/anon. partner?			Patient's HIV status? <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown		
Had sex w/o condom?			Was patient counseled for HIV?		
Had sex while intoxicated/high?			Prior STD history?		
Exchanged drugs/money for sex?			Infection/date:		
Females – had sex w/known MSM?			Met partners via internet/app? <input type="checkbox"/> FB <input type="checkbox"/> Meet Me <input type="checkbox"/> Tinder <input type="checkbox"/> Grinder <input type="checkbox"/> Bumble Other:		
Had sex w/known IDU?			Patient screened: <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Other:		
Been incarcerated?			Partners referred to agencies offering free/reduced cost testing/tx?		
Injection drug use?			Reason for exam? <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Contact to STD <input type="checkbox"/> Prenatal		

***DISPOSITION CODES**

- | | | |
|-----------------------------------|------------------------------------------|----------------------------------------------------|
| A. Preventative treatment | D. Infected, not treated | G. Insufficient information to begin investigation |
| B. Refused preventative treatment | E. Previously treated for this infection | H. Unable to locate |
| C. Infected, brought to treatment | F. Not infected | J. Located, refused examination |
| Comment Section: | | K. Out of jurisdiction |

Local Health Department Reviewer: _____ <input type="checkbox"/> New Case <input type="checkbox"/> OOJ on _____ to _____ <input type="checkbox"/> Update of prior report <input type="checkbox"/> Final/Completed report	<input type="checkbox"/> Called: ___/___/___ by ___; ___/___/___ by ___; ___/___/___ by ___ <input type="checkbox"/> VM <input type="checkbox"/> spoke <input type="checkbox"/> Texted: ___/___/___ by ___; ___/___/___ by ___; ___/___/___ by ___ <input type="checkbox"/> FB msg (<input type="checkbox"/> responded) <input type="checkbox"/> Letter mailed on ___/___/___ by ___ (<input type="checkbox"/> responded)
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