

## CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE CASE REPORT

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

PATIENT INFORMATION							
LAST NAME		FIRST NAME			MIDDLE INITIAL		
ADDRESS		TELEPHONE ( ) ( ) ( )	REASON FOR EXAM (Check one) <input type="checkbox"/> Symptomatic <input type="checkbox"/> Routine Exam – No Symptoms <input type="checkbox"/> Exposed to Infection				
CITY/TOWN		STATE	ZIP CODE				
DATE OF DIAGNOSIS MO   DAY   YR		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH MO   DAY   YR				
ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	RACE – Check all that apply <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander			GENDER OF SEX PARTNERS <input type="checkbox"/> Male <input type="checkbox"/> Both <input type="checkbox"/> Female <input type="checkbox"/> Unknown			
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: _____ <b>DATE TESTED:</b> _____		<b>SITE(S) - ✓ 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"/> Ceftriaxone <input type="checkbox"/> Azithromycin <input type="checkbox"/> Cefixime <input type="checkbox"/> Doxycycline <input type="checkbox"/> Other: _____ <b>DATE RX:</b> _____		<b>SYPHILIS</b> <input type="checkbox"/> Primary (Chancere, etc.) <input type="checkbox"/> Secondary (Rash, etc.) <input type="checkbox"/> Early Latent (<1 yr) <input type="checkbox"/> Late Latent (>1 yr) <input type="checkbox"/> Congenital <input type="checkbox"/> Neurosyphillis <input type="checkbox"/> Late <b>RX GIVEN:</b> _____ <b>DATE RX:</b> _____	
<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: _____ <b>DATE TESTED:</b> _____		<b>SITE(S) - ✓ all that apply</b> <input type="checkbox"/> Cervix <input type="checkbox"/> Rectum <input type="checkbox"/> Urethra <input type="checkbox"/> Pharynx <input type="checkbox"/> Urine <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: _____ <b>DATE RX:</b> _____		<b>HERPES SIMPLEX</b> <input type="checkbox"/> Genital (initial infection only) <input type="checkbox"/> Neonatal Laboratory Confirmation <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 <u>all</u> partners treated (medications available). 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). <i>Health Department assistance recommended if:</i> <ul style="list-style-type: none"> <li>• Patient has had 2 or more sex partners in the last 60 days, or</li> <li>• Patient does not think he/she will have sex again with sex partners from the last 60 days, or</li> <li>• Patient is unable or unwilling to contact one or more partner, or</li> <li>• Patient is a man who has sex with other men.</li> </ul> <b>Note:</b> You may also choose this option if you are providing partner treatment for one or more partners (free meds available) <u>and</u> would like Health Department assistance for additional partners.							
REPORTING CLINIC INFORMATION							
DATE		DIAGNOSING CLINICIAN					
FACILITY NAME		PERSON COMPLETING FORM					
ADDRESS		TELEPHONE					
CITY	ST	ATE	EMAIL				



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

## PARTNER MANAGEMENT PLAN INSTRUCTIONS

### Gonorrhea or Chlamydial Infection: Partner Treatment

**All partners should be treated as if they are infected.**

**If the provider takes responsibility to ensure partner treatment**, the provider should examine and treat all patient's sex partners from the previous 60 days.

If this is **not** possible, patients should be offered medication to give to as many of their sex partners as they are able to contact and/or should be referred to Benton-Franklin County Health District for partner notification assistance.

**Free medication is available for your patient's partner(s).**

**To obtain FREE medication** for your patient's partner(s), call or fax a prescription to one of the pharmacies participating in your area.

For a **prescription FAX form** and list of participating pharmacies, call **Benton-Franklin County Health District: 509-460-4243**.

**Note: Only participating pharmacies have** stocks of **FREE Public Health medication** to dispense to patients for their partner(s).

Benton-Franklin County Health District may also provide free medication to your patient to give to his or her partner(s).

The Benton-Franklin County Health District recommends that you refer patients with any one or more of the following risks to the health department for help notifying their partners:

- Patient with 2 or more sex partners in the last 60 days , or
- Patient does not think he/she will have sex again with sex partners from the last 60 days, or
- Patient is unable/unwilling to contact one or more partner(s), or
- Patient is a man who has sex with other men

Although the Health Department requests that you refer patients with these risks to us, we also ask that you make every effort to help patients with these risks assure that their partners are treated, either by seeing the partners yourself or by offering patients free medication to give to their partners.

**Complete the partner management plan** on the Confidential Sexually Transmitted Disease Case Report FAX form to define a partner management plan.

For copies of this case report or questions on how to fill it out, call the Benton-Franklin County Health District: 509-460-4243.

### Other STDs: Partner Treatment

All patients with infectious syphilis, chancroid, LGV or granuloma inguinale are routinely contacted by Benton-Franklin County Health District. Patients diagnosed with genital herpes should be advised to notify their sex partners and should be informed that their partners should contact their provider for testing.

## 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,  
**OR** Doxycycline 100 mg PO BID for 7 days

**Alternatives:**

Cefixime.....400 mg PO as a single dose, **PLUS** Azithromycin 1g PO as a single dose,  
**OR** Doxycycline 100 mg PO BID for 7 days

**OR**

Azithromycin.....2g PO as a single dose

Fluoroquinolones (Levofloxacin or Ciprofloxacin, etc.) are no longer recommended for the treatment of gonorrhea due to increased prevalence of quinolone-resistant *Neisseria gonorrhoeae* (QRNG).

**Chlamydia trachomatis (uncomplicated):**

Azithromycin.....1g PO as a single dose, **OR**  
 Doxycycline .....100 mg PO BID for 7 days

**Alternatives:**

Erythromycin .....(base) 500 mg PO QID for 7 days, **OR** (ethylsuccinate) 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 (latent > 1 year, 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 CDC 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.



**Washington State STD Expedited Partner Therapy Project  
Fax Prescription for STD Treatment Packs**

**TO:**

Pharmacy: <u>Check (✓) Pharmacy in Table Below</u>	Date: _____
Rx: Patient Name: _____ (intended recipient)	DOB: _____
Person Picking up Meds: _____	DOB: _____
<p><b>Rx: Dispense medications as checked below at no charge to patient. Medications to be dispensed without childproof safety cap.</b></p>	
<input type="checkbox"/> Public Health Pack 1: Azithromycin, 1 gram (Zithromax) PO once stat	<input type="checkbox"/> <b>No known adverse drug reactions</b>
<input type="checkbox"/> Public Health Pack 2: Cefixime 400 mg (Suprax) once PO stat and Azithromycin, 1 gram (Zithromax) PO once stat	<input type="checkbox"/> <b>Unknown adverse drug reactions</b>
_____ Provider Signature (Dispense as Written)	_____ Provider Signature (Substitutions Permitted)

Indicate (✓) Pharmacy To Dispense Medications - Participating Pharmacies in Benton-Franklin County				
✓	Pharmacy Name	Fax #	Address	Phone
	Rite Aid #5317	509-783-3321	101 N Ely St Kennewick	509-783-1438
	Rite Aid #5315	509-545-4587	215 N 4 <sup>th</sup> Ave Pasco	509-547-2231
	Rite Aid #5318	509-946-6769	1549 George Washington Way Richland	509-946-5770
	Safeway #1593	509-882-4763	610 E Wine Country Rd Grandview	509-882-1060

**FROM:**

Prescribing Provider Contact Information	
Name: _____	Fax: _____
Address: _____	Phone: _____