

**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			CITY			STATE		ZIP CODE	
DATE OF BIRTH			TELEPHONE			EMAIL			
MO	DAY	YR	( ) ( ) ( )						
SEX			ETHNICITY		RACE (Check all that apply)			GENDER OF SEX PARTNERS	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgendered Male to Female <input type="checkbox"/> Transgendered Female to Male			<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander			<input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both <input type="checkbox"/> Unknown	
If Female, PREGNANT?			REASON FOR EXAM (Check one)			HIV TESTED AT THIS VISIT?*			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			<input type="checkbox"/> Symptomatic <input type="checkbox"/> Routine Exam – No Symptoms <input type="checkbox"/> Exposed to Infection			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previous Positive  <small>*If newly HIV positive, complete and submit the HIV/AIDS Case Report</small>			
DATE OF DIAGNOSIS									
MO	DAY	YR							
DIAGNOSIS – DISEASE									
<b>GONORRHEA (lab confirmed)</b>					<b>SYPHILIS</b>				
DIAGNOSIS - ✓ only one		SITE(S) - ✓ all that apply			TREATMENT - ✓ all prescribed			<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"/> Late (with symptoms) <input type="checkbox"/> Congenital <input type="checkbox"/> Also Neurosyphilis	
<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: _____		<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"/> Ocular <input type="checkbox"/> Other: _____			<input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Azithromycin <input type="checkbox"/> Cefixime <input type="checkbox"/> Doxycycline  <input type="checkbox"/> Other: _____			<input type="checkbox"/> Genital (initial infection only) <input type="checkbox"/> Neonatal Laboratory Confirmation <input type="checkbox"/> Yes <input type="checkbox"/> No	
DATE TESTED: _____		DATE TESTED: _____			DATE RX: _____			RX GIVEN: _____ DATE RX: _____	
<b>CHLAMYDIA TRACHOMATIS (lab confirmed)</b>					<b>HERPES SIMPLEX</b>				
DIAGNOSIS - ✓ only one		SITE(S) - ✓ all that apply			TREATMENT - ✓ all prescribed			<input type="checkbox"/> Genital (initial infection only) <input type="checkbox"/> Neonatal Laboratory Confirmation <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic-Uncomplicated <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Ophthalmia <input type="checkbox"/> Other Complications: _____		<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"/> Ocular <input type="checkbox"/> Other: _____			<input type="checkbox"/> Azithromycin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Doxycycline <input type="checkbox"/> Ofloxacin <input type="checkbox"/> Levofloxacin  <input type="checkbox"/> Other: _____			<input type="checkbox"/> Chancroid <input type="checkbox"/> Granuloma Inguinale <input type="checkbox"/> Lymphogranuloma Venereum	
DATE TESTED: _____		DATE TESTED: _____			DATE RX: _____				
REPORTING CLINIC INFORMATION									
DATE		FACILITY NAME				DIAGNOSING CLINICIAN			
ADDRESS				CITY			STATE		ZIP
PERSON COMPLETING FORM				TELEPHONE			EMAIL		
				( ) ( ) ( )					

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

**PRIVILEGED AND CONFIDENTIAL COMMUNICATIONS:** 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.

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

<b>GONORRHEA—UNCOMPLICATED</b>
Ceftriaxone ..... 250 mg IM as a single dose..... <b>PLUS</b> Azithromycin 1g PO as a single dose
<b>Alternatives:</b>
Cefixime ..... 400 mg PO as a single dose..... <b>PLUS</b> Azithromycin 1g PO as a single dose <b>OR</b>
For beta-lactam allergic patients:
Azithromycin....2g PO as a single dose... <b>PLUS</b> Gentamicin 240mg IM as a single dose <b>OR</b> Gemifloxacin 320mg PO as a single dose
<b>CHLAMYDIA—UNCOMPLICATED</b>
Azithromycin.....1g PO as a single dose
<b>OR</b>
Doxycycline..... 100 mg PO BID for 7 days
<b>Alternatives:</b>
Erythromycin(base).....500 mg PO QID for 7 days <b>OR</b>
Ethylsuccinate.....800 mg PO QID for 7 days <b>OR</b>
Ofloxacin..... 300 mg PO BID for 7 days <b>OR</b>
Levofloxacin..... 500 mg PO for 7 days
<b>SYPHILIS—PRIMARY, SECONDARY OR EARLY LATENT (&lt;1 YEAR)</b>
Benzathine penicillin G ..... 2.4 million units IM in a single dose
<b>SYPHILIS—LATE LATENT, LATENT OF UNKNOWN DURATION, TERTIARY (NOT NEUROSYPHILIS)</b>
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 (<http://www.cdc.gov/std/tg2015/default.htm>) for further information on treating pregnant patients, infections of the pharynx, treatment of infants and other details.