

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									
GONORRHEA (lab confirmed)					SYPHILIS				
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"/> DATE RX: _____ RX GIVEN: _____ DATE RX: _____	
DATE TESTED: _____									
CHLAMYDIA TRACHOMATIS (lab confirmed)					HERPES SIMPLEX				
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"/> DATE RX: _____ OTHER <input type="checkbox"/> Chancroid <input type="checkbox"/> Granuloma Inguinale <input type="checkbox"/> Lymphogranuloma Venereum	
DATE TESTED: _____									
PARTNER MANAGEMENT PLAN ✓ Select method of ensuring partner treatment									
1. <input type="checkbox"/> Provider will ensure <u>all</u> partners are treated (FREE 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).									
								Partner Plan Instructions Over 	
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.

PARTNER MANAGEMENT PLAN INSTRUCTIONS

Gonorrhea or Chlamydial Infection: Partner Treatment

All partners should be treated as if they are infected.

The Washington State Department of Health strongly encourages providers to take responsibility to ensure partner treatment for heterosexuals, by examining and treating all patient's sex partners from the previous 60 days.

If an examination is **not** possible, providers should offer medication for all sex partners whom patients are able to contact. **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, see page 3 or call **Grays Harbor County Public Health & Social Services Department: 360-532-8631.**

NOTE: Only participating pharmacies have stocks of FREE public health medication to dispense to patients for their partner(s).

Grays Harbor County Public Health & Social Services Department may also be able to provide free medication to your patient to give to his or her partner(s), if resources permit.

Grays Harbor County Public Health & Social Services Department recommends you refer **all MSM patients** and **all patients with syphilis or newly diagnosed HIV** to the health department for help notifying partners to ensure that partners receive medication, the opportunity to test for HIV, syphilis, gonorrhea, and chlamydia, and evaluation for HIV Pre-Exposure Prophylaxis (PrEP). Please inform the patient that the health department will contact them to assist with partner notification.

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 assure that their partners are treated, either by seeing the partners yourself or by offering heterosexual 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 Grays Harbor County Public Health & Social Services Department: 360-532-8631.

Other STDs: Partner Treatment

All patients with infectious syphilis, chancroid, LGV or granuloma inguinale are routinely contacted by Grays Harbor County Public Health & Social Services Department. 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

Alternatives:

Cefixime 400 mg PO as a single dose..... **PLUS** Azithromycin 1g PO as a single dose **OR**

For beta-lactam allergic patients:

Azithromycin....2g PO as a single dose...**PLUS** Gentamicin 240mg IM as a single dose **OR** Gemifloxacin 320mg PO as a single dose

CHLAMYDIA—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—LATE LATENT, 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 the Centers for Disease Control and Prevention's (CDC's) website (<http://www.cdc.gov/std/tq2015/default.htm>) 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 (J) Pharmacy in Table Below</u>	Date: _____
Rx: Patient Name: _____ <small>(intended recipient)</small>	DOB: _____
Person Picking up Meds: _____	DOB: _____
Rx: Dispense medications as checked below at no charge to patient. Medications to be dispensed without childproof safety cap.	
<input type="checkbox"/> Public Health Pack 1: Azithromycin, 1 gram (Zithromax) PO once stat	<input type="checkbox"/> No Known adverse drug reactions
<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"/> Unknown adverse drug reactions
_____ Provider Signature (Dispense as Written)	_____ Provider Signature (Substitutions Permitted)

Indicate (J) Pharmacy To Dispense Medications – Participating Pharmacies in Grays Harbor County				
J	Pharmacy Name	Fax #	Address	Phone
	Rite Aid #5282	360-533-1622	301 E Wishkah St Aberdeen	360-533-6320
	Rite Aid #5283	360-538-9819	310 N Myrtle St Aberdeen	360-533-5531

FROM:

Prescribing Provider Contact Information

Name: _____ **Fax:** _____

Address: _____ **Phone:** _____