

Kitsap County Health District
360-813-1168 (Confidential FAX Line)

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 MO DAY YR		TELEPHONE ()		EMAIL	
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgendered Male to Female <input type="checkbox"/> Transgendered Female to Male		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"/> Black <input type="checkbox"/> Other <input type="checkbox"/> Unknown <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"/> Female <input type="checkbox"/> Both <input type="checkbox"/> Unknown		If Female, PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		REASON FOR EXAM (Check one) <input type="checkbox"/> Symptomatic <input type="checkbox"/> Routine Exam – No Symptoms <input type="checkbox"/> Exposed to Infection	
DATE OF DIAGNOSIS MO DAY YR		HIV TESTED AT THIS VISIT?*		*If newly HIV positive, complete and submit the HIV/AIDS Case Report	
DIAGNOSIS – DISEASE					
GONORRHEA (lab confirmed) DIAGNOSIS - ✓ only one <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: _____ DATE TESTED: _____			SITE(S) - ✓ all that apply <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: _____		TREATMENT - ✓ all prescribed <input type="checkbox"/> Ceftriaxone <input type="checkbox"/> Azithromycin <input type="checkbox"/> Cefixime <input type="checkbox"/> Doxycycline <input type="checkbox"/> Other: _____ DATE RX: _____
			HERPES SIMPLEX <input type="checkbox"/> Genital (initial infection only) <input type="checkbox"/> Neonatal Laboratory Confirmation <input type="checkbox"/> Yes <input type="checkbox"/> No		SYPHILIS <input type="checkbox"/> Primary (Chancre, 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 RX GIVEN: _____ DATE RX: _____
CHLAMYDIA TRACHOMATIS (lab confirmed) DIAGNOSIS - ✓ only one <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Symptomatic-Uncomplicated <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Ophthalmia <input type="checkbox"/> Other Complications: _____ DATE TESTED: _____			SITE(S) - ✓ all that apply <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: _____		TREATMENT - ✓ all prescribed <input type="checkbox"/> Azithromycin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Doxycycline <input type="checkbox"/> Ofloxacin <input type="checkbox"/> Levofloxacin <input type="checkbox"/> Other: _____ DATE RX: _____
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 **Kitsap County Health District: 360-307-4309.**

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

Kitsap County Health District may also be able to provide free medication to your patient to give to his or her partner(s), if resources permit.

Kitsap County Health District 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 Kitsap County Health District: 360-307-4309.

Other STDs: Partner Treatment

All patients with infectious syphilis, chancroid, LGV or granuloma inguinale are routinely contacted by Kitsap 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

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: Check (J) Pharmacy in Table Below

Date: _____

Rx: Patient Name: _____
(intended recipient)

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.**

- Public Health Pack 1:** Azithromycin, 1 gram (Zithromax) PO once stat
 Public Health Pack 2: Cefixime 400 mg (Suprax) once PO stat
 and Azithromycin, 1 gram (Zithromax) PO once stat

- No Known adverse drug reactions**
 Unknown adverse drug reactions

Provider Signature (Dispense as Written)

Provider Signature (Substitutions Permitted)

Indicate (J) Pharmacy To Dispense Medications – Participating Pharmacies in Kitsap County

J	Pharmacy Name	Fax #	Address	Phone
	Rite Aid #5254	360-479-8571	4117 Kitsap Way Bremerton	360-479-2415
	Rite Aid #5260	360-876-9114	3282 Bethel Rd SE Port Orchard	360-876-0969
	Rite Aid #5261	360-697-5979	19475 7 th Ave NE Poulsbo	360-697-2209
	Rite Aid #5266	360-692-5387	2860 NW Bucklin Hill Rd Silverdale	360-692-3410

FROM:

Prescribing Provider Contact Information

Name: _____ **Fax:** _____

Address: _____ **Phone:** _____