

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)	
<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	
GENDER OF SEX PARTNERS					
<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	
DATE OF DIAGNOSIS		*If newly HIV positive, complete and submit the HIV/AIDS Case Report			
MO	DAY	YR			
DIAGNOSIS – DISEASE					
GONORRHEA (lab confirmed)			SYPHILIS		
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: _____			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: _____			<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		
DATE TESTED: _____			DATE RX: _____		
RX GIVEN: _____			DATE RX: _____		
CHLAMYDIA TRACHOMATIS (lab confirmed)			HERPES SIMPLEX		
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: _____			<input type="checkbox"/> Genital (initial infection only) <input type="checkbox"/> Neonatal Laboratory Confirmation <input type="checkbox"/> Yes <input type="checkbox"/> No		
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 TESTED: _____			DATE RX: _____		
OTHER					
<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 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 **Mason County Department of Health Services: 360-427-9670 ext 406.**

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

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

Mason County Department of Health Services 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 Mason County Department of Health Services: 360-427-9670 ext 406.

Other STDs: Partner Treatment

All patients with infectious syphilis, chancroid, LGV or granuloma inguinale are routinely contacted by Mason County Department of Health Services. 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 Mason County

J	Pharmacy Name	Fax #	Address	Phone
	Safeway #1571	360-275-0999	23961 NE Route 3 Belfair	360-275-0953
	Safeway #0585	360-426-2497	600 Franklin St Shelton	360-426-0718
	Fred Meyer #603	360-432-5367	301 E Wallace-Kneeland Shelton	360-432-5373

FROM:

Prescribing Provider Contact Information

Name: _____ **Fax:** _____

Address: _____ **Phone:** _____