Washington State Department of Health

FAX Page 1 To:
Walla Walla County Health Department
509-524-2642 (Confidential FAX Line)

Adapted from WA DOH Form 347-102

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
- ☐ Male
- ☐ Female
- ☐ Transgendered Male to Female
- ☐ Transgendered Female to Male

ETHNICITY
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown

RACE (Check all that apply)
- ☐ White ☐ Asian
- ☐ Black ☐ Other ☐ Unknown
- ☐ American Indian/Alaskan Native
- ☐ Native Hawaiian/Other Pacific Islander

GENDER OF SEX PARTNERS
- ☐ Male
- ☐ Female
- ☐ Both
- ☐ Unknown

If Female, PREGNANT?
☐ Yes ☐ No ☐ Unknown

DATE OF DIAGNOSIS
MO / DAY / YR

REASON FOR EXAM (Check one)
- ☐ Symptomatic
- ☐ Routine Exam – No Symptoms
- ☐ Exposed to Infection

HIV TESTED AT THIS VISIT?*
☐ Yes ☐ No ☐ Previous Positive

*If newly HIV positive, complete and submit the HIV/AIDS Case Report

DIAGNOSIS – DISEASE

GONORRHEA (lab confirmed)

DIAGNOSIS - ✓ only one
- ☐ Asymptomatic
- ☐ Symptomatic-Uncomplicated
- ☐ Pelvic Inflammatory Disease
- ☐ Ophthalmia
- ☐ Disseminated
- ☐ Other Complications: _____

DATE TESTED: _____

SITE(S) - ✓ all that apply
- ☐ Cervix
- ☐ Urethra
- ☐ Urine
- ☐ Rectum
- ☐ Pharynx
- ☐ Vagina
- ☐ Ocular
- ☐ Other: _____

TREATMENT - ✓ all prescribed
- ☐ Ceftriaxone ☐ Azithromycin
- ☐ Cefixime ☐ Doxycycline
- ☐ Other: _____

DATE RX: _____

SYPHILIS

- ☐ Primary (Chancre, etc.)
- ☐ Secondary (Rash, etc.)
- ☐ Early Latent (<1 yr)
- ☐ Late Latent (>1 yr)
- ☐ Late (with symptoms)
- ☐ Congenital
- ○ Also Neurosyphillis

RX GIVEN: _____

DATE RX: _____

CHLAMYDIA TRACHOMATIS (lab confirmed)

DIAGNOSIS - ✓ only one
- ☐ Asymptomatic
- ☐ Symptomatic-Uncomplicated
- ☐ Pelvic Inflammatory Disease
- ☐ Ophthalmia
- ☐ Other Complications: _____

DATE TESTED: _____

SITE(S) - ✓ all that apply
- ☐ Cervix
- ☐ Urethra
- ☐ Urine
- ☐ Rectum
- ☐ Pharynx
- ☐ Vagina
- ☐ Ocular
- ☐ Other: _____

TREATMENT - ✓ all prescribed
- ☐ Azithromycin ☐ Erythromycin
- ☐ Doxycycline ☐ Ofloxacin
- ☐ Levofloxacin
- ☐ Other: _____

DATE RX: _____

HERPES SIMPLEX

- ☐ Genital (initial infection only)
- ☐ Neonatal

Laboratory Confirmation
☐ Yes ☐ No

OTHER

- ☐ Chancroid
- ☐ Granuloma Inguinale
- ☐ Lymphogranuloma Venereum

PARTNER MANAGEMENT PLAN ✓ Select method of ensuring partner treatment

1. ☐ **Provider will ensure all partners are treated (FREE medications available). Indicate number to be treated (_____).**
2. ☐ **All partners have been treated. Indicate number treated (_____).**
3. ☐ **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 **Walla Walla County Health Department**: 509-524-2650.

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

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

Walla Walla County Health 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 Walla Walla County Health Department: 509-524-2650.

Other STDs: Partner Treatment

All patients with infectious syphilis, chancroid, LGV or granuloma inguinale are routinely contacted by Walla Walla County Health 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/tg2015/default.htm) for further information on treating pregnant patients, infections of the pharynx, treatment of infants and other details.*

Washington State Department of Health

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

TO:

Pharmacy: ***Check (√) Pharmacy in Table Below*** **Date:** _____

Rx: Patient Name: _____ **DOB:** _____
(intended recipient)

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 (√) Pharmacy To Dispense Medications – Participating Pharmacies in Walla Walla County				
√	**Pharmacy Name**	**Fax #**	**Address**	**Phone**
	Rite Aid #5320	**509-529-2990**	2028 E Isaacs Ave Walla Walla	509-529-1917
	Safeway #0307	**509-522-0327**	215 Rose St Walla Walla	509-522-0227

FROM:

Prescribing Provider Contact Information

Name:_____**Fax:** _____

Address:_____**Phone:** _____